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TELEGRAPHIC ADDRESS—LANCET, WESTRAND LONDON TELEPHONE NUMBER—GERRARD 5356

No. XXI. of Vol. II., 1913.
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## CONTENTS.

*The whole of the literary matter in THE LANCET is copyright.*

**AN ADDRESS** on the Origin and Growth of the Royal College of Surgeons of England. Delivered on the Occasion of the Opening of the American College of Surgeons, by Sir RICKMAN J. GODLEE, Bart., M.S. Lond., F.R.C.S. Eng., &c., Surgeon-in-Ordinary to H.M. the King; Surgeon, University College Hospital, &c. ..... 1443

**AN ADDRESS** on Some Requirements for Modern Clinical Teaching. Delivered before the Medical Institution of Liverpool on Nov. 6th, 1913, by Sir DYCE DUCKWORTH, Bart., M.D., LL.D., F.R.C.P., Honorary Member of the Institution; Consulting Physician to St. Bartholomew's Hospital and the Italian Hospital; Senior Physician to the Seamen's Hospital, Greenwich ..... 1448

### ORIGINAL ARTICLES.

The Treatment of Neurasthenia. By J. S. RISIEN RUSSELL, M.D. Edin., F.R.C.P. Lond., Professor of Clinical Medicine and Physician to University College Hospital; Physician to the National Hospital for the Paralysed and Epileptic, Queen Square ..... 1453

Notes on Four Cases of Ureteral Calculus in one of which a Complete Cast of the Ureter was Present. By HAROLD COLLINSON, M.S. Lond., F.R.C.S. Eng., Assistant Surgeon, Leeds General Infirmary.—(*Illustrated*) ..... 1456

The Primary Cause of Rheumatoid Arthritis. By H. WARREN CROWE, M.D. Oxon.—(*Illustrated*) ..... 1460

A Case of Tumour of the Pituitary Body. By A. L. TAYLOR, B.Sc., M.B. Edin., M.R.C.P. Edin., Assistant Medical Officer, Derby Borough Asylum.—(*Illustrated*) ..... 1464

### MEDICAL SOCIETIES.

ROYAL SOCIETY OF MEDICINE:
CLINICAL SECTION:—Exhibition of Clinical Cases.—The Treatment of Syphilis 1465
SECTION OF OBSTETRICS AND GYNÆCOLOGY:—Relation of Internal Secretions to Female Characteristics and Functions in Health and Disease ..... 1467
SECTION OF ANÆSTHETICS:—Tachycardia during Anæsthesia.—Paroxysmal Tachycardia.—Anoci-Association ..... 1468
SECTION OF LARYNGOLOGY:—Exhibition of Cases and Specimens ..... 1469

MEDICAL SOCIETY OF LONDON:
The Treatment of Neurasthenia ..... 1469

HARVEIAN SOCIETY:
Fractures about the Elbow-joint.—Peculiar Characteristics of Tuberculous Sputa 1472

EDINBURGH MEDICO-CHIRURGICAL SOCIETY:
Valedictory Address.—The Suprarenal Glands ..... 1473

GLASGOW MEDICO-CHIRURGICAL SOCIETY:
Prevention of Malaria ..... 1474

MANCHESTER MEDICAL SOCIETY:
Some Clinical Types of Early Mitral Stenosis ..... 1475

INCORPORATED SOCIETY OF MEDICAL OFFICERS OF HEALTH:
Natural History of Pulmonary Tuberculosis in Scotland ..... 1475

MANCHESTER PATHOLOGICAL SOCIETY:
Exhibition of Cases, &c. ..... 1475

### REVIEWS AND NOTICES OF BOOKS.

A History of University Reform from 1800 A.D. to the Present Time, with Suggestions towards a Complete Scheme for the University of Cambridge. By A. I. Tillyard, M.A. ..... 1476

Contributions to Practical Medicine. By Sir James Sawyer, M.D. Lond., F.R.C.P. Lond. Fifth edition 1476

The Development of the Human Body: a Manual of Human Embryology. By J. Playfair McMurrich, A.M., Ph.D., LL.D. Fourth edition ..... 1477

Abhandlungen über Salvarsan. Gesammelt und mit einer Vorrede und Schlussbemerkungen herausgegeben von Professor Paul Ehrlich ..... 1477

Hygiene and Public Health. By Louis C. Parkes, M.D. Lond., D.P.H., and Henry R. Kenwood, M.B. Edin., F.R.S. Edin. Fifth edition... 1477

Die Chirurgie der Blutgefässe und des Herzens. Von Dr. Ernst Jeger ..... 1478

Das Wechselstrombad. By Professor A. Strubell ..... 1478

Minds in Distress: a Psychological Study of the Masculine and Feminine Mind in Health and in Disorder. By A. E. Bridger, B.A., B.Sc. Paris, M.D. Lond., F.R.S. Edin. ..... 1478

Resuscitation from Electric Shock, Traumatic Shock, Drowning, Asphyxiation from any Cause. By Charles A. Lauffer, A.M., M.D. ..... 1478

Dictionary of German and English and English and German. By Max Bellows. 1478

Miscellaneous Volumes ..... 1479

Quarterly Journal of Experimental Physiology ..... 1480

The Child ..... 1480

### NEW INVENTIONS.

Gastro-Enterostomy Clamps.—(*Illustrated*) ..... 1481

### LEADING ARTICLES.

THE UNIVERSITY OF LONDON: THE POSITION OF THE GOVERNMENT ..... 1482

FLORENCE NIGHTINGALE ..... 1483

### ANNOTATIONS.

Mosquitoes in and about Epping Forest ..... 1484

Eyesight and Navigation ..... 1484

Ureteral Calculus with Pain Greatest on the Opposite Side ..... 1485

"Defixiones" ..... 1485

The Varnished Frog ..... 1486

Spinal Injuries Due to Ski-Jumping ..... 1486

The Greenland Vikings and the White Esquimaux ..... 1487

The American College of Surgeons ..... 1488

VITAL STATISTICS:
Health of English Towns ... 1493
Health of Scotch Towns ..... 1493
Health of Irish Towns ..... 1494

### SPECIAL ARTICLES.

The London County Council and Medical Affairs ..... 1481

The International Conference on Tuberculosis ..... 1488

Medicine and the Law ..... 1490

Royal Commission on Venereal Diseases ..... 1490

Annual Report for 1911 of the Registrar-General.—(*To be concluded*) ..... 1491

Royal College of Surgeons of England: Meeting of Council ..... 1492

Report of the Sanitary Commissioner with the Government of India for 1911.—(*To be concluded*) ..... 1492

The Services ..... 1494

Medical Practice under the Insurance Act. XXVII.—Derby, Derbyshire, and County Practice.—(*To be continued*) ..... 1498

### HOME AND FOREIGN NOTES.

(FROM OUR OWN CORRESPONDENTS).

Sheffield ..... 1498

Bristol and Western Counties 1499

Scotland ..... 1500

Ireland ..... 1501

### OBITUARY.

Charles McBurney, M.D., late Professor of Clinical Surgery, Columbia University, New York ..... 1502

### THE NATIONAL INSURANCE ACT.

The New Draft Regulations for Medical Benefit and Mr. Danckwerts's Opinion ..... 1507

The Accumulated Funds in London ..... 1508

Norfolk Insurance Committee 1508

Approved Societies and Expenses of Administration... 1508

London Medical Committee... 1508

Shoreditch Medical Union ..... 1508

The Supply of Medicines by Medical Men to Insured Persons ..... 1509

A Protest against a Sanatorium for Tuberculosis ..... 1509

The late Dr. Horace Dimock... 1509

### CORRESPONDENCE.

The Accuracy of Clinical Thermometers (Dr. Mary H. Williams) ..... 1502

Workmen and Hernia (Mr. J. E. H. Roberts) ..... 1503

Protection Against X Ray Burns (Dr. James H. Sequeira) ..... 1503

Sulphur in Gas (Dr. Charles Carpenter) ..... 1503

Big Game and Sleeping Sickness versus Man and his Animals (Prof. J. L. Todd)... 1504

The Duties and Status of the School Medical Officer (Dr. C. W. Hutt) ..... 1504

Poliomyelitis in England (Mr. Malcolm Stewart) ..... 1505

"Twins" or Superfœtation (Dr. James Oliver) ..... 1505

The Honorary Staff of the Mount Vernon Hospital and the Committee of Management (Mr. C. Johnston) ..... 1506

The Government of the Royal College of Surgeons (Mr. R. Brudenell Carter) ..... 1506

The National Insurance Act (Dr. T. Cuming Askin) ..... 1507

Vagitus Uterinus (Dr. D. D. Lee) ..... 1507

London Nerve Clinic (School of Psychotherapy) (Dr. Edwin Ash) ..... 1507

The Case of Mr. H. T. Hamilton (Dr. W. H. Gimblett) ..... 1513

Intestinal Stasis (Dr. John Haddon) ..... 1513

### MEDICAL NEWS.

City of London Hospital for Diseases of the Chest ..... 1448

Literary Intelligence ..... 1464

German Congress for Internal Medicine ..... 1475

Presentation to a Medical Man 1481

London (Royal Free Hospital) School of Medicine for Women ..... 1481

University of London: Award of University Medals ..... 1488

Medico-Legal Society ..... 1495

Scarlet Fever in London ..... 1495

Central Midwives Board ..... 1498

Donations and Bequests ..... 1502

Pass-lists of the University of Oxford; University of Cambridge; Royal Colleges of Physicians of London and Surgeons of England; and Royal College of Surgeons of England ..... 1509

Medical Barristers ..... 1510

The Position of Prison Medical Officers ..... 1510

Epsom College ..... 1510

King Edward's Hospital, Cardiff ..... 1510

Poor-law Medical Officers' Association of England and Wales ..... 1510

Antarctic Medals ..... 1511

The District Council of Ilford and the Medical Officer of Health ..... 1511

Midland Obstetrical and Gynæcological Society ..... 1511

Books, &c., received ..... 1511

Appointments ..... 1511

Vacancies ..... 1511

Births, Marriages, and Deaths 1512

Notes, Short Comments, and Answers to Correspondents 1513

Medical Diary ..... 1514

Acknowledgment of Communications received ..... 1516

FOR INDEX TO ADVERTISEMENTS SEE PAGES 2 & 4.

# INDEX

## MEDICAL AND OTHER BOOKS AND PUBLICATIONS


PAGE

**BAILLIERE, TINDALL & COX:—**

Adams & Cassidy .. Acute Abdominal Diseases ..... 7
Bigg ..... Indigestion ..... 8
Campbell .. Treatment .... Cover 1
Chapin & Pisek .... Diseases of Infants and Children ..... 7
Clarke, E. .. Errors of Accommodation, &c. .. Cover 1
Dieulafoy .. Medicine ..... 7
Freyer .... Enlargement of the Prostate ..... 8
" .... Urinary Organs ..... 8
Gardner .. Surgical Anæsthesia Cover 1
Harston .... European Children in the Tropics ..... 7
Jones ..... Psycho-Analysis ..... 7
Kanavel .... Infections of Hand .. 7
Mummery .. Sigmoidoscope Cover 1
Schmieden. Operative Surgery .. 7
Simon ..... Infection and Immunity ..... 7
Thorne .... Nauheim Treatment of Diseases of the Heart ..... Cover 1
Vulpius .... Infantile Paralysis .. 7
Wolff-Eisner .. Clinical Immunity & Sero-Diagnosis .... 7

**BALE, SONS & DANIELSSON:—**

Bandelier & Roepke .. A Clinical System of Tuberculosis ..... 8
" Tuberculin in Diagnosis & Treatment 8
Biedl ..... The Internal Secretory Organs ..... 8
De Quervain Clinical Surgical Diagnosis ..... 8
Garre & Quincke.. Surgery of the Lung.. 8
Lohmann .. Disturbance of the Visual Functions .. 8
Lorenz & Saxl ..... Orthopædics ..... 8
Moullin .... Inflammation of the Appendix .... Cover 1
Elmer .... Epidemic Infantile Paralysis ..... 8
Stewart .... Practical Chemistry 8
Thompson . Compendium of the Pharmacopœias, &c. 8

PAGE

**CASSELL & CO:—**

Morris, Sir M..... Diseases of the Skin.. 8

**CHURCHILL, J. & A.:—**

Bolton & Revis .... Fatty Foods ..... 3
Carruthers. Urine Examination.. 3
Clouston .. Mental Diseases .... 3
Coles ..... The Blood ..... 3
" ..... Clinical Diagnostic Bacteriology ..... 3
Cripps .... Cancer of the Rectum 8
" .... Diseases of Rectum.. 8
Cuff ..... Lectures to Nurses .. 3
Edelmann .. Meat Hygiene ..... 3
Fenwick .. The Value of Radiography .... Cover 1
Galabin & Blacker .. Midwifery ..... 3
Goodhart, Sir J. F., & Still.... Diseases of Children 3
Hare ..... Alcoholism.... Cover 1
Hawk ..... Practical Physiological Chemistry .... 3
Hewlett .... Bacteriology ..... 3
" .... Pathology ..... 3
" .... Serum and Vaccine Therapy ..... 3
Jellett..... Midwifery for Nurses 3
Mayland.... Abdominal Surgery .. 3
Sequeira .. Diseases of the Skin.. 3
Taylor .... Medicine ..... 3
Thorne, Bezly .... Schott Nauheim Treatment of Heart 8

**CONSTABLE & CO:—**

Shennan .. Post Mortems, &c. .. 10

**FROWDE:—**

Berkart .... On Bronchial Asthma Cover 1

**HADDON:—**

A Doctor's Discovery ..... 10
The Father's Will and How to Know It ..... 10

**LEWIS:—**

Allen ..... Vaccine Therapy .... 5
Campbell .. Headache .... Cover 1
" .. Flushing, &c... " 1
" .. Nervous Organisation of Man and Woman Cover 1

PAGE

**LEWIS—(Continued).**

Coleman & Hilliard .. Anæsthetics ..... 5
Jones .... Medical Electricity .. 5
" ..... Ionic Medication .... 5
Krause .... Surgery of Brain, &c.. 5
Moullin .... Enlargement of the Prostate .... Cover 1
" .... Tumours ..... " 1
Paget ..... For & Against Experiments on Animals.. 5
Powell, Sir R. D., & Hartley Diseases of the Lungs and Pleuræ ..... 5
Rawling .... Landmarks, &c., of the Human Body .. 5
Swanzy & Werner .. Diseases of the Eye.. 5

**LONGMANS, GREEN & CO.:—**

Abney, Sir W. de W... Colour Vision ..... 11
Ashby ..... Notes on Physiology.. 11
Cheyne, Sir W., & Burghard. Surgical Treatment.. 11
Colyer ..... Dental Surgery, &c... 11
Gray ..... Anatomy ..... 11
Grünbaum.. Morbid Histology .... 11
Halliburton Chemical Physiology. 11
Herschell & Abrahams Chronic Colitis Cover 1
Lickley .... Nervous System..... 11
Plimmer ... Practical Physiological Chemistry .... 11
Quain's Dictionary of Medicine .. 11
Schäfer, Sir E. A... Histology ..... 11
Watson-Williams. Rhinology ..... 8
White, &c.. Alimentary Toxæmia Cover 1

**MACMILLAN & CO.:—**

Adami & McCrae .. Pathology ..... 6
Ballance .. Cerebral Decompression in Ordinary Practice ..... 6
Cook, Sir E. The Life of Florence Nightingale ..... 6
King ..... Feeding and Care of Baby ..... 6
Luciani .... Human Physiology .. 6
Milligan & Wingrave. Diseases of the Ear.. 6
New System of Medicine ..... 6
Paton ..... Metabolism ..... 6
Rolleston .. Diseases of the Liver, &c. ..... 6
Tubby ..... Deformities .. Cover 1

PAGE

**MEDICAL PUBLISHING CO.:—**

Lane, Sir W. A.. Operative Treatment of Fractures. Cover 1
" Cleft Palate and Hare Lip ..... Cover 1

**NISBET & CO.:—**

Lane, Sir W. A.. Treatment of Chronic Constipation. Cover 1
Romer & Creasy .. Bonesetting and the Treatment of Painful Joints.... Cover 1

**SAUNDERS COMPANY:—**

De Schweinitz Diseases of the Eye.. 9
Eyre ..... Bacteriological Technique ..... 9
Fowler .... The Operating Room and the Patient .... 9
Friedenwald & Ruhräh .. Diet ..... 9
Jordan .... General Bacteriology 9
Kemp ..... Stomach, Intestines, and Pancreas ..... 9
Saunders' New Edition of Successful Books ..... Cover 1

**UNIVERSITY OF LONDON PRESS:**

Bernstein .. Applied Pathology .. 10
Bidwell .... Minor Surgery ..... 10
Cole ..... Mental Diseases .... 10
Evans ..... Diseases of the Skin.. 10
Fox ..... Medical Hydrology .. 10
Marshall .. Diseases of the Eyes.. 10
Mortimer .. Anæsthesia and Analgesia ..... 10
Stevens .... Diseases of Women .. 10
Turner & Carling .. Treatment after Operation ..... 10
Whipham .. Medical Diseases of Children ..... 10

**WRIGHT & SONS (Bristol):—**

Mummery .. Diseases of the Colon Cover 1

**MEDICAL LIBRARIES, &c.:—**

Behnke—Stammering ..... 8
Ketley—Stammering ..... 10
Matthews Bros.—Wood: Application of Trusses 10
Waterston & Sons—The Doctor's Daily Register .. 10


## OFFICIAL AND GENERAL ANNOUNCEMENTS


PAGE

**APPOINTMENTS VACANT:—**

Argyle and Bute Asylum, Lochgilphead ..... 74
Bethnal Green Infirmary ..... 74
Birmingham and Midland Hosp. for Skin and Urinary Diseases .. 71
Bolton Union ..... 75
Bradford Poor-law Union Hospital, &c. ..... 72
Breconshire County Council ..... 74
Bristol Royal Infirmary ..... 70
Bury and District Joint Hospital Board ..... 70
Cambridgeshire County Council 74 75
Cancer Hosp. Research Institute.. 74
Chester General Infirmary ..... 71
Cornwall Works Dispensary, Smethwick ..... 74
County Asylum, Chester ..... 73
County Asylum, Dorchester ..... 71
Coventry and Warwickshire Hosp. 72
Dorset County Hos., Dorchester .. 71
Down County Council ..... 75
Dreadnought Hospital, Greenwich 73
East London Hos. for Children, Shadwell ..... 72
East Sussex County Council Education Committee ..... 70
Enfield Education Committee ..... 75
Essex County Hosp., Colchester .. 74
Glasgow Maternity and Women's Hospital ..... 74
Great Yarmouth Hospital ..... 71
Guest Hospital, Dudley ..... 72
Hampstead General and North-West London Hospital ..... 73
Hospital for Diseases of the Skin, Blackfriars ..... 73
Hospital for Sick Children, Great Ormond-street ..... 73
Huddersfield Royal Infirmary .... 73
India Office ..... 71
Italian Hospital ..... 71
Joint Counties Asylum, Carmarthen ..... 72
Kent County Asylum, Maidstone .. 71
King Edward VII.'s Hos., Cardiff. 73
Lancashire Education Committee. 72

PAGE

**APPOINTMENTS—(Continued).**

Liverpool Eye and Ear Infirmary .. 73
Macclesfield General Infirmary .. 73
Manchester Education Committee 71
Metropolitan Asylums Board .... 74
Miller General Hospital ..... 74
National Hospital for Diseases of the Heart ..... 72
National Hosp. for the Paralysed and Epileptic ..... 74
New Hospital for Women, Eastonroad ..... 72
Newcastle-upon-Tyne Education Committee ..... 71
Newcastle-upon-Tyne and Northumberland Sanatorium ..... 71
Noble's Hospital, Douglas, Isle of Man ..... 71
Nottingham General Dispensary.. 73
Oxford County Asylum, Littlemore 71
Queen Mary's Hosp. for Children, Carshalton ..... 75
Rochdale Infirmary ..... 72
Romsley Hill Sanatorium for Consumptives, near Birmingham 75
Royal Albert Edward Infirmary and Dispensary, Wigan ..... 70
Royal Asylum, Morningside, Edinburgh ..... 74
Royal College of Physicians ..... 74
Royal Ear Hospital, Soho ..... 71
Royal Hospital, Richmond, Surrey 71
Royal Infirmary, Hull ..... 71
Royal Infirmary, Sheffield ..... 70
Royal Isle of Wight County Hos., Ryde ..... 72
Royal Mineral Water Hos., Bath.. 73
Royal Portsmouth Hospital ..... 72
Royal Surrey County Hospital, Guildford ..... 73
St. Bartholomew's Hos., Rochester 73
St. Mary's Hospital, Paddington.. 73
St. Mary's Hospital for Women and Children, Plaistow ..... 70
Somerset & Bath Asylum, Cotford. 72
South London Hospital for Women 74
Southampton Free Eye Hospital .. 75
Swansea Union ..... 71
Throat Hospital, Golden-square .. 74

PAGE

**APPOINTMENTS—(Continued).**

University of London ..... 70
Victoria Hos. for Children, Chelsea 71
Victoria Infirmary of Glasgow .... 74
Walsall and District Hospital .... 73
West Herts Hospital, Hemel Hempstead ..... 72
West London Hospital, Hammersmith-road ..... 72
West Sussex and Chichester Joint Education Committee ..... 72
Wilts County Asylum, Devizes.... 71
Worcester General Infirmary..... 75

**ASSISTANCIES, MEDICAL:—**

Arnold & Sons, Giltspur-street... 76
Clifford, Forest Hill ..... 76
E. C., Kew ..... 75
Hume, Gordon-square ..... 76
No. 855, L.O., Strand ..... 76
Scholastic, Clerical, &c., Association, Craven-street ..... 75
Turner ..... 76

**ASYLUMS, HOMES, &c.:—**

Ashwood House, Kingswinford .. 62
Association of Medical Men Receiving Resident Patients ..... 69
Barnsley Hall, Bromsgrove ..... 62
Barnwood House Hospital ..... 63
Bishopstone House, Bedford..... 62
Bootham Park, York ..... 62
Broadlands, Medstead ..... 69
Brunton House, Lancaster ..... 69
Buntingford House Retreat, Buntingford ..... 64
Camberwell House, Peckham-road 64
Cheadle Royal ..... 63
City of London Mental Hos., Stone 69
Clarence Lodge, Clapham-park .. 62
Colthurst House, Alderley Edge .. 62
Coppice, The, Nottingham ..... 63
Dairymple House, Rickmansworth 65
Dartmoor Sanatorium ..... 65
David Lewis Colony, Alderley Edge 62
Duff House, Banff ..... 66
Ghyllwoods ..... 65
Grove House, Church Stretton.... 63

PAGE

**ASYLUMS—(Continued).**

Grove, The, Catton, Norwich..... 63
Haslemere Nursing Home ..... 70
Haydock Lodge, Newton-le-Willows ..... 64
Haynes, Brentwood ..... 69
Helgham Hall, Norwich ..... 62
Holmesdale, Hastings ..... 70
Home for Epileptics, Maghull .... 62
Invernith Lodge Sanatorium, Colinsburgh ..... 65
Kingsdown House, Box ..... 69
London Fever Hospital ..... 63
Maison de Santé de Glain-les-Liége (Belgium) ..... 66
Malling Place, Kent ..... 63
Melbourne House, Leicester ..... 69
Mendip Hills Sanatorium ..... 67
Meyrick, Brighton ..... 70
Middleton Hall, Co. Durham..... 62
Moat House, Tamworth ..... 65
Mount Pleasant, Wanstead ..... 69
Mount Vernon Hospital for Consumption ..... 67
Mundesley Sanatorium ..... 66
Newmains Retreat, Lanarkshire.. 65
Nordrach-on-Dee, Banchory ..... 66
Northumberland House, Finsbury-park ..... 62
Northwoods House, Winterbourne 64
Norwood Sanatorium, Ltd..... 65
No. 502, L.O., Strand ..... 70
Osea Island, Heybridge..... 65
Peckham House ..... 64
Pendyffryn Hall Sanatorium, Nordrach-in-Wales ..... 66
Plympton House, Plympton ..... 65
Portsmouth Corporation Mental Hospital ..... 62
Queen Alexandra Sanatorium, Davos Platz ..... 68
Ringwood & Inge, Hayling Island. 70
Ruebury Sanatorium, Northallerton ..... 61
St. Andrew's Hospital, Dollis Hill 70
St. Andrew's Hosp., Northampton 65
St. Luke's Hos. for Mental Diseases 62
Shaftesbury House, Formby-by-the-Sea..... 64


*For continuation of Index to Official and General Announcements, and Trade and Miscellaneous Advertisements, see page 4.*

# An Address
ON
# THE ORIGIN AND GROWTH OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

*Delivered on the Occasion of the Opening of the American College of Surgeons,*

BY SIR RICKMAN J. GODLEE, BART., M.S. LOND., P.R.C.S. ENG., &C.,
SURGEON-IN-ORDINARY TO H.M. THE KING; SURGEON, UNIVERSITY COLLEGE HOSPITAL, ETC.

GENTLEMEN,—At the beginning of the fourteenth century your ancestors and mine were living side by side—probably many of us have common ancestors—in those small islands from which I come. From which I come in response to your call, on a mission so honourable and responsible that, much as I appreciate the honour done to my College and to myself as its representative, I almost sink under the burden of its responsibility. I refer to this date because it has been suggested that some account of the origin and growth of the Royal College of Surgeons of England might be interesting to this assembly. Our attention is therefore for the moment fixed upon London and upon the earliest records of any attempt to regularise the practice of surgery in that already ancient capital of the British Empire.

## THE GILDS OF BARBERS AND OF SURGEONS.

It is difficult for any of us, and most of all for you who have discarded almost all pomps and ceremonies, to visualise old England, primitive but stately, in 1308, the year after that weak King Edward II. had succeeded his politic and warlike father. It was near the end of the Middle, or the Dark, Ages. The new Parliament of Lords and Commons had hardly begun to make its influence felt upon the feudal system. The echo of the Crusades had scarcely died away in Europe, and England was constantly at war with France or Scotland. Everyone of any consequence bore arms, suits of mail and swords and bows. In fact, the military spirit pervaded everything, including the Church, and art and science were under a dark cloud.

Medicine was not in advance of the other sciences. Its practitioners were for the most part monks, or, if not ecclesiastics, cloaked their ignorance by the gravity of their semi-clerical attire.

In these early days surgery was regarded as a mere handicraft—much less dignified than medicine. For long surgeons were associated in the popular mind with the barbers, and even 200 years later we find them placed in the same list as "comon bakers, bruers or scryvenors." The barbers let blood and did other minor surgical operations, and those surgeons who belonged to the Barbers' Gild were not above scraping a chin or clipping a poll in their spare moments. Both trades were largely recruited from the continent, and both, no doubt, contained many undesirable aliens. Thus it was that Richard le Barbour, living opposite the church of All Hallows the Less, was elected and presented by the barbers of London, on Tuesday the Feast of St. Lucy the Virgin (Dec. 13th, New Style), 1308, to Nicholas de Faryngdon, then Mayor of London, and was appointed Supervisor of the Gild, and swore the Barbers' oath, from the words of which it may be gathered that there were some very black sheep indeed in the profession in those days. This is the first mention in the City Records of the Barbers' Gild.

The better class of surgeons, known as the master surgeons, apparently held aloof and formed themselves into another association called the Gild of Surgeons. When this Gild of Surgeons was founded it is impossible to say, but we know that by 1368 surgeons were recognised as a distinct body, and in 1492 they were granted arms (the original of which is still preserved in Barbers' Hall). I prefer the words of their license to those of the Barbers' oath. They promised "well and truly to serve the people in their cures, to take of them reasonable fees, to exercise their mystery [which means *mestier* or trade] faithfully, to report to the Mayor and Aldermen any surgeon neglecting his patients, and to give information to the city officers of the hurt, wounded, or otherwise in peril of death."

### *The Origin and Development of Gilds.*

It is interesting to think of the origin of these Gilds, although it is one of those doubtful questions which are the delight of speculative historians. Perhaps it is to be sought in the purely pagan and Scandinavian idea of wergeld, or the price of blood, or possibly it is founded on the Christian idea of brotherhood. Be that as it may, we find in England soon after the Norman Conquest, over and above religious gilds with which we have nothing to do, both in the large and small boroughs what was known as the "gild merchant," an association distinct from the municipality for the protection of trade in general. From the gild merchant, as it were by a process of fission (like that which perhaps unfortunately is taking place so frequently in our own profession to-day), were separated the gilds of particular crafts. As these grew more powerful and more numerous the parent body became superfluous and obsolete and gradually disappeared. The gilds then were associations or fraternities of all the artisans of a single branch of industry in a particular town for mutual protection and support, for the supervision of the craft and regulating the hours of labour. They always retained something of the religious element. Charity and almsgiving in sickness and old age were never forgotten, and brotherly feasts or banquets appear to have been the *sine qua non*.

In London these gilds in the course of time gave place to the City Companies. They became very important bodies, they elected and still elect the Lord Mayor and Corporation, and had judicial functions independent of the Crown.

In the time of Edward III. everyone belonging to a craft was obliged to join a company; and surgery being recognised as a craft it was essential that surgeons should either join the gild or company to which they were most closely associated—namely, the Barbers—or should form one of their own. As a matter of fact, as we have seen, both these courses were adopted.

The master surgeons, forming the Surgeons' Gild, who no doubt represented the *élite* of the profession, gradually gained strength and influence, and it is not surprising that considerable friction occurred between them and the barbers practising their minor surgery. It may be noted in passing that in those early days the master surgeons recognised the practice of women, and held some of their writings in high esteem, notably those emanating from the University of Salerno.

There is no time, and it would be tedious, to dwell upon the various steps by which the barbers became a City Company, acquired a coat of arms, and lived sometimes at peace but oftener at variance with the Gild of Surgeons. For the present also a passing reference only is made to the promising but unfortunately short-lived associated College of Medicine and Surgery and the establishment of the College of Physicians in 1518, on the model of the Paris College. To this and the disagreement between the two branches of our profession I will return later.

### THE COMPANY OF BARBER-SURGEONS.

But now, leaving all this very ancient history, I will direct your attention to a period 200 years after the time of Richard le Barbour, when in 1542 or thereabouts the Barbers' Company and the Gild of Surgeons were incorporated as the Company of Barber-Surgeons.

These two centuries had been marked by universal and extraordinary progress. The dark ages had given place to the Renaissance or the revival of learning. Printing had been invented, rendering knowledge common property; gunpowder had been discovered; and the most important branch of the surgery of those days had thus been profoundly modified, while the general outlook of the world had been changed by the voyage of Columbus to your continent across the Atlantic. There were still frequent wars and rumours of wars. England itself had hardly settled down after the Wars of the Roses, but the military spirit was less preponderant. Our mutual forefathers were with much travail shaking off the tyranny of Rome, and the real spirit of the age was inspired by the cultivation of art, science, and the *literæ humaniores*.

Our own science had been revolutionised by Ambroise Paré, Paracelsus (that erratic genius), and others, and it is not to be wondered at that surgeons were becoming more important and perhaps more aggressive.

There was a tendency, from the point of view of concentrating force and avoiding friction, for the different City Companies to amalgamate. New economic conditions caused the pendulum to swing back, and diffusion again was giving place to concentration. It was to promote peace and secure uniformity that the new Company of Barber-Surgeons was formed, the outward and visible record of which is Holbein's notable picture in Barbers' Hall. To stand before it is to grasp the spirit of the age. Henry VIII. in gorgeous robes of State gazes loftily into space, as if with a soul above such trifles, holding a drawn sword in the right hand, while with the left he casually presents the charter to the kneeling barbers and surgeons, appropriately clad in their black caps and flowing fur-tipped robes. Amongst them is to be seen Thomas Vicary, the first Master. This was the gentle-minded Thomas Vicary, sergeant-chyrurgeon to the King and overseer of all the officers at St. Bartholomew's Hospital. He was the author of "The Englishman's Treasure with the True Anatomie of Man's Body," in which, amongst other noble thoughts, he gives this sound advice to surgeons:—

> And see they neuer prayse themselves for that redoundeth more to their shame and discredite than to their fame and worship: For a cunning and skilful Chirurgeon neede neuer vaunt of his dooings, for his works wyll euer get credite ynough. Likewise that they despise no other Chirurgeon without a great cause: for it is meete that one Chirurgeon should love another, as Christ loueth vs al. And in thus dooing they shal increase both in vertue and cunning to the honour of God, and worldly fame, to whome he bring vs al. Amen.

### THE SURGEONS' COMPANY.

The unnatural union of Barbers and Surgeons lasted for another 200 years, but it was never a success. The contracting parties were incompatible, and the incompatibility increased as surgery began to emancipate itself from the superstitions and traditions of the elders under the influence of advancing scientific thought and discovery. During these two centuries much had taken place on both sides of the Atlantic. Spanish, Portuguese, Germans, Dutch, French, and English had migrated in large numbers to North America; and the English colonies were exerting more and more pressure on their Spanish and French neighbours. In England the Stuarts and the Commonwealth had come and gone, and the House of Hanover was firmly established on the throne when in 1745, after 60 years of agitation, the Surgeons' Company was separated from the Barber-Surgeons by Act of Parliament.

In obtaining their release the Surgeons were only following the example of Paris, Edinburgh, and Glasgow; but the Barbers naturally resented this divorce from their more distinguished and more prosperous partners. So they drew up a reasoned protest in which they finally urge:—

> But if for other reasons (which the Surgeons say *may* be given) the Parliament shall be inclined to favour them in this part of their Report the Barbers, from the scrupulous Regard and Tenderness which that august assembly has always shown for *private Property*, cannot but hope that they shall be *continued* in the enjoyment of all their Possessions without any diversion whatsoever.

And so it was settled. The Barbers kept everything—hall, plate, and pictures, and the Surgeons had to make a fresh start on their own account. Cheseldon, who, in his scarlet coat, watches over our Council meetings, was a prime mover in the change, and Mr. Ranby, sergeant surgeon to George II., was the first Master.

### THE FUNCTIONS OF THE COMPANY OF BARBER-SURGEONS.

In order to grasp the evolution of our College we must glance at the functions—*quoad* surgery—of the Barber-Surgeons during this second period in our historical review. The orthodox training for a surgeon was by means of apprenticeship, and the Company supervised the quality and training of the apprentices and examined them before granting the licences, which then had to be approved by the Bishop of London or the Dean of St. Paul's. At times they had trouble with these worthies, who were apt to give licences on their own account without proper examination. The Company also gave licences, sometimes partial, sometimes temporary, to foreigners, and it is to be feared sometimes to the merest quacks. They also did not hesitate to take them away again if occasion arose.

The licensing of naval surgeons was also committed to them. One of their important functions was the public dissection and teaching of anatomy, the only form of anatomical study recognised by law. For this purpose the bodies of four executed criminals were allowed each year. Another was the appointment of public lecturers or readers on surgery. But this was apparently not a very successful venture. Besides this they exercised a censorship over the books of their members, and had the power of summary commital for minor offences.

But the fact of belonging to an important City Company hampered the surgeons greatly. They had to take part in City functions and public pageants, and were heavily assessed for public objects, such as the repair of St. Paul's Cathedral, or Irish necessities. Countless dinners exhausted their coffers, and it is not to be wondered at that their valuable plate was frequently at pawn, and that at one time the Company actually became bankrupt. One cause of their difficulties was the rise and increasing prosperity of the medical schools with their more attractive, shorter, and less expensive system of training or apprenticeship—less expensive because no part of the hospital fees was wasted in defraying the cost of civic extravagance.

### THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

And now, since the separation of the Surgeons from the Barbers and the formation of the Surgeons' Company, another 200 years has almost passed away, and our College stands before the world *totus atque rotundus*, for criticism or praise. Let us shortly glance at the intervening period.

The new Company passed through many vicissitudes, monetary and domestic, both in their original quarters in the Old Bailey and also in our present house in Lincoln's Inn-fields. In 1800 they were established as the Royal College of Surgeons in London by a charter of George III., and in 1843 the name was changed, by a charter of Queen Victoria, to the Royal College of Surgeons of England. In the meantime the ancient titles of Master, Governors, and Court of Assistants had been replaced by those of President, Vice-Presidents, and Council.

I will not burden you with a detailed account of the gradual development of our constitution, nor of the steps by which the corporation was enlarged to its present size. But it will interest you to hear that under the 1843 Charter a *new Class of Members, who were to be called Fellows*, was formed, from and by whom the Council were to be elected, instead of, as was previously the case, by the Council themselves. The idea was to enlarge the franchise without making it unwieldy, and in practice I think it works well. But there are murmurs from a small but active section of the Members, whose shibboleth is the phrase, "the modern idea of representative government." Students who passed the necessary examinations obtained their *quid pro quo*—the diploma of Member—which carried the right to practise and certain privileges, exemptions, and immunities. They also became by law an actual part of the body corporate. If this had not been the case, and if they had been called Licentiates, as is the case at the College of Physicians or the Apothecaries' Hall, they would have had no suspicion of a claim to the franchise. And if our College were still struggling and impecunious it is possible that the high philosophical, democratic idea would not have suggested itself. Now the Members number over 17,000, most of them busy general practitioners; they are scattered over the three kingdoms and the colonies, and many are in the services. They would form an unpollable constituency, and it may reasonably be feared that if universal suffrage were adopted only the comparatively few advocates of the change would be represented, and that an attempt would be made to import an expensive socio-political element (now well looked after by other bodies) into what is undoubtedly the proper function of the College.

#### *The Fellowship of the College.*

The first Fellows, 300 in number, were chosen from the Members. They were elected by the Council, chiefly from the surgeons, assistant surgeons, and lecturers of the metropolitan hospitals. A second batch of 242, elected in 1844, included many representatives of the Naval, Military, and Indian Forces. Since then the ordinary portal to the Fellowship has been an examination, or rather two examinations, which together constitute a formidable and searching test of ability. Our critics say that the number of rejections at them is out of all reason, and I am not prepared to say that the criticism is unworthy of consideration. At the same time it must be remembered that the Fellowship is not a mere qualification to practise, but is intended to mark its holders as having undergone a thorough training and examination in anatomy, physiology, pathology, and surgery, and also that in spite of all its difficulties there is no lack of candidates for what is the most coveted British surgical distinction. The number of Fellows is now 1589.

An elected Fellowship is to form the first Corpus of your College, but you will be faced with the problem of its renewal and enlargement if it is to be an active, moving force. I will therefore briefly describe our method of attaining this result, because it appears preferable to that which is adopted by the Royal Society and the Royal College of Physicians of London—namely, to elect a certain number of Fellows every year. Ours, at all events, excites no jealousy and causes no heartburning. I know it has been suggested that the presentation of a thesis might replace or supplement an examination. But it must be remembered that many excellent practical surgeons might find this an arduous, if not an impossible, task; and also that the professional thesis writer is not unknown where this practice prevails.

#### *The Examinations for the Fellowship.*

For the First Professional Examination four examiners in anatomy and four in physiology are selected from the professors in these subjects at universities and medical schools. The papers of each candidate are read and marked by two examiners in anatomy and two in surgery. Each candidate is then subjected to a searching oral and practical examination by the other two examiners acting together. No candidate is examined by his own teacher, and successful candidates must obtain a high percentage of the total marks. For the Second Professional Examination the ten examiners are surgeons on the staffs of large hospitals connected with medical schools. It consists of a written paper, an elaborate clinical examination, both written and oral, operative surgery on the cadaver, surgical anatomy and surgical pathology. In each part the candidate is examined by two different examiners, one questioning and the other assessing. Thus, before the ordeal is complete, he has appeared before all ten examiners, and on their joint award he is either passed or rejected.

If you contemplate anything of the sort and desire that the diploma shall indicate, not only that a man can pass a severe examination, but that he has been thoroughly well trained, you will be well advised to lay down a special curriculum (I speak the word with dread) over and above that required in the ordinary university course, and to frame the examinations on a standard even higher than the highest degree examinations. It is, in my opinion, essential that the examination should be

conducted independently of any medical school, and that the examiners should be chosen only from those who are actually engaged in teaching. It is also highly advisable that examiners should, whenever it is possible, be Fellows of your College and that no candidate should be examined by his own teacher.

Before leaving the subject of the Fellowship it is proper to state that our Council have the right to appoint *ad eundem* Fellows, but there is only one of these. They can also elect to the Fellowship annually two Members of 20 years' standing, but this privilege also is sparingly used. By a charter of 1908 (which was the centenary of the College) a new order of Honorary Fellows, limited to 50 in number, was instituted. This includes a few personages of distinction who do not belong to our profession, as well as representatives of the flower of surgery in all parts of the world, some of whom I am proud to think form part of my audience.

*The College: Museum and Library.*

I must now pass to the consideration of what we are and what we do to-day, though the thought obtrudes itself, What use can these musty old traditions and tedious evolutions be to you who are in the act of springing fully armed like Minerva from the head of Jove? It requires an effort to appreciate the youth of this enormous city. When Lister was planning his visit to the United States in 1884 he turned up his ordinary everyday atlas to study the route and looked first for Chicago, but lo, it was not to be found! Will you bear a little longer with the prattle of one who, compared with yourselves, is like a pliocene pithecanthropos?

We are now, as things go, in comfortable circumstances. Our affairs are well managed and we can put by against the day of adversity—a very necessary precaution in these times of political instability and social unrest. The College, a large and dignified building, standing on freehold property, contains amongst other things a theatre, laboratories, a library, and the museum.

The nucleus of the museum is the famous collection of that genius who may almost be called our patron saint, John Hunter. It was bought by the nation, and though it was handed over to our custody it is actually in the hands of trustees. It is thus a national institution, but the greater part of it is our own, for we have spent since 1800 no less than £500,000 upon it. It is now probably the best of its kind in the world, and is resorted to largely for study and research. The development and improvement of the museum is one of our primary duties.

The library contains 60,000 volumes and perhaps an equal number of pamphlets. This of course is small as compared with those of the Faculté de Médecine at Paris, or the Militär-Medizinische Akademie at St. Petersburg, or your own magnificent Surgeon-General's Library at Washington. It is, however, if not the best, one of the two best medical libraries in London, and is very largely used.

*The Council: Disciplinary Functions.*

The affairs of the College are managed by a Council of 24, who cannot sit for more than eight years without re-election and seldom serve for more than two terms. The Council meets once a month. Most of the work is done by committees; it is concerned with public as well as our own private affairs. The Council have also certain disciplinary functions and supervise the examinations for our own special diplomas (the Fellowship, the Diploma of Public Health, and the Dental Diploma), as well as those granted in common with the College of Physicians.

In speaking of the disciplinary functions it must be remembered that our General Medical Council has definite judicial powers over registered medical practitioners entrusted to it by Parliament. It can institute inquiries, take evidence, and deliver judgment. It can erase the names from the Register of those found "guilty of conduct infamous in a professional respect." Our College has only jurisdiction over its own Fellows or Members, and is not in the same sense a judicial body, but it often investigates complaints and, accepting the decisions of the courts of law or the General Council, deprives members of their diplomas, sometimes restores them, or issues reprimands for minor offences, and thus endeavours to maintain the respectability and dignity of the profession. It is a very delicate subject and one which I am sure will give you very serious matter for thought. You will be fortunate if you escape the criticisms sometimes made upon our actions, either that we have proceeded with too great temerity or with excess of caution.

Possibly it is the hope of some active promoters of this scheme that a system of ethics may be set up and enforced acceptable to the whole North American continent. It is a Herculean task, not unworthy of a modern Hercules.

In studying our own history one is struck by the fact that the crime of one age may be either unthinkable or altogether condoned in the next. In old days punishment was inflicted on an unlicensed person for hanging out a flag to indicate that he was a surgeon, or on a surgeon for wilfully exposing his dirty bleeding cups in the shop front, or—observe—for prescribing an internal remedy. Touting for patients is an old offence, but the Insurance Act with us appears to be forcing the censors to judge it less harshly. And not only Time, but Place, exerts its influence on the code of medical ethics. What may be considered merely bad taste, or hardly that, in one country is disgraceful in another. Even the method of issuing an advertisement makes all the difference in the eyes of the moralist. So that sometimes as the black ball is reluctantly dropped into the box I seem to hear the words of the parable, "Let him that is without sin amongst you cast the first stone." When I think of your vast continent, of its polished eastern civilisation, of its wild west and its even wilder south, I feel sure that in the matter of discipline you will have to tread with cautious steps lest you should defeat your object; bearing in mind the words of Thomas Vicary quoted above, "likewise that they despise no other Chirurgeon without great cause."

EXAMINATIONS.

The subject of examinations is a dry one, but it is worthy of your serious consideration; and I trust that by omitting any further reference to the Fellowship and the special diplomas it may be possible to hold your attention.

Many of the time-honoured institutions in England are the result of slow growth, of patching together and preserving what is good in the old and by degrees eliminating the bad. The result is often passable but not perfect, and our system of medical examinations in the three kingdoms shares the fate of many arrangements of the kind. *Video meliora proboque* (I recognise and approve of something better) should be our motto, and I gather that your

position, at all events in the States, is not a much more happy one.

My own view is, but I commit no one else in expressing it, that the ideal plan would be that in every country the qualification to practise should be granted as the result of a uniform examination, controlled or authorised by the State, something much more practical and efficient than the German Staatsexamen. And by *State* I mean not one of your States, but *country*, for I do not think it possible that a single scheme should be adopted by a huge continent like this, with its Latin and Teutonic elements living side by side. Canada is showing the way, and I can imagine that the United States and Mexico—each surely large enough to form a unit (the United States is indeed probably far too large for the purpose)—might take a hint from the Dominion, where, as I understand, a General Medical Council has been formed which will in future control the examinations which alone will confer the right to practise. There are other ways in which the result might be obtained; but even if this were a suitable occasion I am not sufficiently acquainted with your special difficulties to pursue the matter further.

In any country where such a test is enforced the examinations for the Fellowship of Colleges and the degrees of Universities need no longer traverse the whole of the medical curriculum, as they would no longer carry the qualification. They need only include whatever special polish the particular body thought it advisable to apply to the individual who had already obtained the seal of his country upon his general fitness to practise his profession.

With us more or less uniformity of standard has been obtained by means of the powers entrusted by the Privy Council (from whom the right to hold qualifying examinations originates) to the General Medical Council, of inspecting and reporting upon the examinations of the far too numerous qualifying bodies. But it is impossible to overlook the dangers of underbidding and underselling, and the unnecessary and unprofitable toil imposed upon the student who may desire to possess, say, both a University degree and our Conjoint diploma.

The serious and prolonged attention that the American Medical Association have devoted to this subject, and the very fact that we are assembled here on an occasion that may almost be called a solemn one, for the inauguration of your College makes it certain that some changes will before long take place. It is my earnest hope that they may be wisely made. Of one thing I am profoundly impressed, that a uniform standard is essential for the best interests of the public and the profession, and that no such uniform standard is likely to be obtained unless the profession is unhampered in its endeavours by political or parochial interference.

Until about 25 years ago the examinations for the Membership of our College of Surgeons included rather trivial examinations in medicine and midwifery, and, like those for the Licence of the College of Physicians, carried a qualification to practise. But in 1884 a Conjoint Examining Board of the two Colleges was formed, on which each is represented and each discharges its own proper function. Successful candidates become Licentiates of the Royal College of Physicians and Members of the Royal College of Surgeons, and there is no other way of obtaining these diplomas. It is not too much to say that these examinations are recognised as being models of fairness and thoroughness and are specially distinguished by their practical character. There are those who hope that, if a State test is ever instituted in the old country, they will at least be taken as its pattern.

### The Relations of Physicians and Surgeons.

This *rapprochement* between the two Colleges is one of the most satisfactory developments of modern times, and is one to which I desire particularly to direct your attention. I am in complete agreement with a recent statement by one of your most thoughtful surgeons, that as surgery becomes more and more scientific and involves the treatment of all the internal organs it is natural that surgeons should be more than mere superficial physiologists and pathologists, that they should become, in fact, physicians as well as surgeons. My own practice has largely been upon the border-land, and I have all my life pointed out that, whereas the pure physician *need* not be conversant with the details of surgery, the more he knows about them the better; but that it is essential for the well-equipped surgeon to make himself acquainted with much of what is considered to be the special domain of the physician. Surgeons who specialise often become adepts in the medical aspects of their own specialities; and it may well happen (if they do not excite jealousy by *practising* as physicians that their opinions will be sought by their medical colleagues, not only in respect of treatment, but also to assist in diagnosis.

The tendency, therefore, ought to be for the two branches of the profession to be drawn more and more closely together, and it may confidently be anticipated that in forming an American College of Surgeons nothing will be done to widen the interval or accentuate the divergence between them.

In London the two Colleges are now on the most friendly terms, and in many matters act in common for the good of the profession and the community. But there is no chance that we shall ever amalgamate. Our traditions are so different; there is but little similarity in our constitutions and our methods of doing business. And seeing that what has been said about single as opposed to married life—"he travels the fastest who travels alone"—is true also of corporations, we shall no doubt each for the most part pursue our own course, completely emancipated, however, from the petty rivalry and discord of former days.

It is strange to think that about 1420 a *College of Medicine and Surgery* was actually established within the liberties of the City of London—that is, you will observe, nearly a century before the foundation of the Royal College of Physicians. It is also a sad reflection that, powerful as it was and promising as its prospects appeared to be, the two parties in it could not succeed in working harmoniously. Later on the two Colleges were often at deadly feud, the principal complaint of the physicians being that the surgeons persisted in administering internal remedies. At one time they positively refused to meet one another in consultation. It is much to be deplored that the original scheme failed. It came too early in the world's history. But in this age of reason, if I were framing the constitution of a modern Utopia, I would found such an associated college, which, of course, would be an unqualified success, for even the schemes of the ancient Utopia, we know, were always not only theoretically unimpeachable, but practically perfect.

### CONCLUDING REMARKS.

Utopia! The word reminds me that on receiving your invitation I thought it might be necessary to adumbrate the *perfect college* which yours I trust will be. But I will not attempt to do so. Your College, by the very nature of things, must be, both in structure and function, totally different from ours, and ignorance of the local conditions would lead me into hopeless difficulties. For example, you may intend it to be, like the Church Universal, an impalpable something enshrined in your minds and consciences, but I can hardly conceive of it without a stately habitation, over the door of which is the inscription, "*Aedes Collegii Chirurgicorum Americanorum.*" Only where? Naturally the first thought that occurs to an Englishman is Washington, but the vast extent of your continent at once suggests objections which might be raised. Again, my idea of a college includes a magnificent and expanding library, but it would be a waste of effort to duplicate your own national Surgeon-General's Library. If your temple ever rears its head, at least I hope that you will have a museum modelled upon, and perhaps some day surpassing, the Hunterian Museum in Lincoln's Inn.

These things are, however, merely the outward coverings and the skeleton of the college. You are the flesh and blood, the circulation, the primæ viæ, the nerves and the brains, and it is for you, and you alone, to work out your own salvation. No advice of mine beyond the hints scattered here and there very tentatively through this address can, I fear, be of any service to you; it is my fervent hope that what I *have* said may at least not appear injudicious or impertinent.

Let me therefore, in conclusion return to the thought with which I began—namely, the happy inspiration that suggested to you to invite the College of Surgeons of England to send their President to mix the caudle cup for your christening. It was, I assure you, most willingly and heartily accepted by them. The brotherhood of science is an intimate relationship, but we are so widely scattered over the face of the globe that it is apt to be overlooked. Anything, therefore, is to be welcomed which helps to remind us that we are all brothers, in spite of diversity of tongues and dividing seas. But in the case of America and England such interchange of thought, such interchange of courtesy and hospitality, have a still deeper and a more important bearing. It is not simply because we are fellow labourers in the same *scientific* fields that we thus meet together—now on this side of the Atlantic, but soon, I hope, on the other—but because as *nations* we have long since beaten our swords into ploughshares, and are intent upon cultivating those fruitful acres of mutual forbearance and respect.

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CITY OF LONDON HOSPITAL FOR DISEASES OF THE CHEST.—The annual dinner of this charity will be held on Dec. 3rd at the Trocadéro Restaurant, London, when Sir Philip Sassoon, Bart., M.P., will take the chair. The hospital, which has 175 beds and over 10,000 out-patients annually, is the second largest hospital in London for consumption. It is situated in a healthy position but remote from wealthy residential parts, and but for substantial recognition by King Edward's Hospital Fund would have suffered severely from pecuniary pressure. The purpose for which the committee of the hospital are at the present moment seeking special assistance from the public is the improvement of the sanitary arrangements in the older portion of the hospital and the modernising of the heating system.

# An Address
ON
# SOME REQUIREMENTS FOR MODERN CLINICAL TEACHING.

*Delivered before the Medical Institution of Liverpool on Nov. 6th, 1913,*

BY SIR DYCE DUCKWORTH, BART., M.D., LL.D., F.R.C.P.,

HONORARY MEMBER OF THE INSTITUTION; CONSULTING PHYSICIAN TO ST. BARTHOLOMEW'S HOSPITAL AND THE ITALIAN HOSPITAL; SENIOR PHYSICIAN TO THE SEAMEN'S HOSPITAL, GREENWICH.

GENTLEMEN,—My first duty is to thank the officers of this institution for this opportunity of addressing my professional brethren in this my native city, a place endeared to me by long and touching memories, not a few of which, indeed, relate to old members of this society, now passed away to their rest.

### MEDICINE AND SCIENCE.

I have selected the subject of clinical teaching because it has become one of supreme interest and importance, and concerns the highest welfare of all our British Schools of Medicine. It is certain that profound changes have occurred within recent years in our clinical methods which were not conceived as possible when many of us were students.

Let me make my standpoint in this matter clear from the outset. It is sometimes asserted that physicians of my standing are now little better than pre-scientific fossils, unfitted to realise or avail themselves of modern methods and research, for which they were never trained, and who therefore venture to believe that they may safely discard them. Thirty-eight years ago Burdon Sanderson expressed his profound conviction "that a future will come, it may be a somewhat distant future, in which the treatment of disease will be really guided by science." Two years later Claude Bernard remarked that "the old traditions are losing ground, and scientific medicine (*la science expérimentale*) has got hold of all our younger men." These were indeed prophetic statements from two great physiologists, and we shall do well to note what has happened in the interval, and ascertain if the practice of medicine has yet reached the high scientific position anticipated for it. We may roughly sum up the advances which have materially altered our methods as results of studies in bacteriology and biochemistry. Many of these have proved fruitful for the benefit of humanity, and we are justified in expecting fresh disclosures in the days to come. They are indeed so remarkable that no intelligent member of our profession can afford to be ignorant of many of these achievements wrested from nature. The laboratory has therefore become an important and essential adjunct to the clinical ward.

Being still engaged in clinical teaching, I venture to assert that while my position and training exclude me from taking any part in laboratory methods and research, I am yet enabled to summon from this source the best expert revelations for the benefit of my patients and my pupils, and I am constantly doing so. I recognise to the full the value and essential importance of all these modern methods, and gladly urge the experts to further advances. We surely know that legitimate medicine can never stand still and live on even the best of its past.

The task before us to-day is complex and indeed difficult for any clinical teacher. He dare not shut his eyes to the achievements of his great predecessors, and yet he must be ready to take advantage of the best modern assured facts and methods of inquiry.

Let it be noted that his great centre in this matter is the true welfare of his patient, for the physician is a healer by profession, and he must secure from all sources the best possible knowledge to enable him to make an exact diagnosis, to treat his patient, and to frame a sound prognosis as to the outcome of any ailment affecting him.

*Medicine as an Art, guided by Scientific Research.*

Modern medicine is now declared to be gradually becoming a branch of experimental science. I do not accept this pronouncement. I prefer to affirm that medicine is an art, guided increasingly by the disclosures of scientific researches, and I venture to declare that if clinical work was conducted at the present time solely from a scientific standpoint, without any reference to the personal factors of our patients, it would often fare badly for them.

The physiologist's standpoint is not that of the physician. The former is not a bedside artist, and has little knowledge of the inward human elements in the ailing human individual. He is often devoid of clinical instincts. His work is impersonal and confined to soulless materials. The physician ministers to mind and soul as well as to tissues and secretions, and he has to discern the subtle difference in the living, though sickly, organisms with which he has to deal. This faculty for observation of the personal factor in each case varies, of course, in different individuals. In some it almost amounts to an instinct, and in any instance can only be acquired by study at the bedside. The physician needs all the best knowledge that the physiologist and biochemical professor can give him, but he has to apply it with prudence in his own way as directed by experience. That is not science properly so-called, but it is a great and imperative requirement for success in practice. Doubtless many bedside problems are best resolved in a clinical laboratory closely adjacent to the patient, and we are now establishing those aids to diagnosis in all our best schools. We may note, however, that if such researches are not conducted by experts they may lead to wrong interpretation, and be unavailing or even harmful.

There are some amongst us who do not hesitate to regard a good deal of the clinical art of to-day as little better than an old-fashioned empiricism, and the modern scientific physician appears to have set himself to dispense with all matters which smack of it. It is supposed to be unnecessary and fruitful of errors. The modern surgeon, it is true, may generally find small place for anything empirical, for he has had little need for such practice, and his work is not seldom plainly set before him. Much more plainly, indeed, to-day owing to the admirable work which surgeons have done of late years in interpreting what Sir Berkeley Moynihan aptly terms "living pathology," especially in respect of the abdominal cavity. The physician readily appreciates most of the fruits of modern surgery, and is gravely in fault if he hesitates to secure promptly such aid as can be secured from the surgeon for his patients. It has to be conceded that surgery has now taken over into its department several chapters in medicine, and our surgical colleagues are ready to deal with every cavity in the body in which operative measures are possible or desirable.

I trust that, thus far, my hearers may give me credit for an open mind in regard to modern methods, and gather that I am unprejudiced and in no degree jealous, but truly very proud, of the splendid achievements of modern surgery.

WHAT EMPIRICISM REPRESENTS.

I have a good deal more, however, to say about the physician and his work, and I would ask you first to consider what empiricism in medicine represents to-day. Sir William Hamilton's definition of the term was: "Experiment or experience without science." I venture to think that such terms can hardly apply to much of the empiricism of this century, for it is certain that the phenomena of disease are now carefully studied by physicians already trained in scientific methods. The results of treatment are no less rigidly noted by them as a scientist would note them. A preferable, but still incomplete, definition of empiricism is: "The product of experience, founded on observation alone." In this case it cannot be an asset in the equipment of any young practitioner. Observation is the keynote of the physician's life work. He should start in practice as a well-trained observer. (I note a special defect in modern preliminary training owing to an inadequate teaching of the subjects of botany and materia medica, which are of much value in promoting observation of details.) Precision and accuracy in seeing and recording are of high value as acquirements. The imperfectly trained observer is often blind to matters that become almost instinctively borne in upon the well-trained one, and as Browning wrote: "Men won't notice; when they do they'll understand."

*The Training of the Student.*

The reformers of our medical curriculum contend that unless a student is scientifically trained to research and to watch for new results his education is defective. I believe that such training is now adequately secured for the average student in his present compulsory studies in the physiological and bacteriological laboratories of our best schools. Original research is hardly possible for him *in statu pupillari*, yet such work has always been carried on by aspiring students who, with exceptional industry and ambition, find time to do it. Modern teaching in all departments is now conducted by scientifically trained observers, and they surely impart the methods and fruits of such training in their daily duties.

I am inclined to believe that the scientists are now unduly pushing their subjects into the curriculum of our students, and thus withdrawing them from an adequate pursuit of their clinical duties. The modern curriculum is indeed heavily loaded already. The exceptional student must be blessed with more time and money than falls to the lot of the ordinary one, and let us remember that the instinct and taste for original work are not universally implanted in the minds of our pupils, who for the most part have to be prepared for the particular practical duties that await them.

We must face the facts with which we have to deal. We do not find the same types of mind in this country which we meet with in foreign countries. Our methods are, and always will be, different. We have to take the best we can secure from all sources, but we shall employ them in our own way as seems most profitable for the end in view. I

believe that we are now doing this in all our best schools, while we pursue methods of our own which it would be well for many foreign schools to adopt. We can at least illustrate for them the art of nursing the sick, surely a clinical matter, and display in our hospital service a ministry of humanity not too readily met with in foreign cities.

*Rational Empiricism.*

I therefore regard the term empirical, in its ordinary sense, as an improper one to apply to a skilled modern medical observer; and I prefer to regard a rational empiricism as a fine part of the *ars medendi*. I have a strong opinion that the best practice of medicine will never be completely covered by what we recognise as science, properly so called. Have we not discovered for ourselves that highly scientific practitioners are not always the best clinicians, nor are they the men to whom we should prefer to trust our lives, or those dear to us, in grave diseases? Such opinions cast no measure of indifference on scientific methods and attainments which must always be appreciated and encouraged.

Sir Oliver Lodge has lately reminded us that "the methods of science are not the only way of arriving at truth," as is now too commonly believed. The two methods, rational-empirical and scientific, are distinct, and equally imperative, and they must be blended as required in our practice. It cannot be denied that a large part of successful medical practice is rationally empirical, and cannot be explained in the terms of an exact science. We can neither afford to wait, nor our patients to suffer, until scientific principles govern all our therapeutic efforts, and we are prepared with exact explanations of their efficacy.

I suppose that the work done by such clinical masters as Bright, Trousseau, Graves, Addison, Jenner, and Murchison, not to mention many others, is now regarded by some of us as of secondary importance and little adapted for modern teaching. Apart from their enduring contributions to pathology and treatment, we must recognise that much of their practice was guided by a rational empiricism which they exerted with skill and trained experience. I maintain that we must still work on similar lines to-day, better equipped indeed than these men were, and seeking our knowledge largely from close and accurate bedside observation. We may remember that these men thought and worked in days of less pressure and strife than those we are living in. There was then more time for meditation and fruitful thinking, less eagerness to produce mere results, and more patient waiting on nature. There were fewer hurried publications of distracting and ephemeral novelties than assail us to-day.

Let it be noted that empiricism has often anticipated science in medicine, and by affording suggestions for profitable research played an honourable part, which it is certain to continue to do in the future.

THE DOCTRINE OF THE DIATHESES.

I pass on next to consider the true relations of experimental research to modern medicine. As I have already stated, I regard the clinical laboratory as one of the best and safest equipments in our new schools, especially because it is in touch with the living patient. It is as human as it can be. (Do not imagine that I am an antivivisectionist.)

The tendency of laboratory training is to lead to the belief that there is a constancy in each unit of humanity, presenting similar proclivities, immunities, and characters in respect of the tissues, metabolisms, and secretions of the body. Yet it does not demand much reflection to indicate that this is not the case. We are not so many ninepins turned off from a lathe out of a block of wood. There are, indeed, infinite differences in human units, and the physician must take due note of them as far as he can. This is entirely a matter of observation relating to varying types of constitution or habits of body, and a recognition of the signs of progressive maladies as expressed in the face and the body generally. A trained student of these varied indications may thus acquire a remarkable insight into the ailments and tendencies of a patient without asking a single question, and so is often rapidly put on the track of the conditions he is likely to meet with.

The teaching of the doctrine of the diatheses, or inherent qualities of bodily texture, is not only now set aside but regarded as effete and useless, and thus a whole chapter of our art is closed to modern students. Half an hour spent once a week with a skilled teacher in physiognomical diagnosis, with proof, or disproof, of the opinions thus formed, corrected by inquiry and physical diagnosis, would prove of great service to senior students, and equip them for accuracy in practice. The eminent French physiologist, Charles Richet, has recently called attention to what he terms "a humoral personality which renders each different from other individuals." Remarking on this, Professor Chauffard, in his remarkable address to the International Congress of Medicine last August, declared that "the findings of modern clinical medicine approximate to and complete the teachings of tradition, and suggest the close connexion of these 'humoral personalities' with the old doctrine of the diatheses."[1]

*The Arthritic and Scrofulous Habits.*

These inquiries are often fruitful. I can give no more pregnant examples of this study than are afforded by the basic arthritic habit of body, and the strumous or scrofulous habit. In the arthritic habit, or diathesis, we find a specific readiness for infection by the peccant bacteriological elements which induce rheumatic fever in the earlier decades of life. Later on we find in this class a marked tendency to the perverse metabolisms which engender gout and the protean phases of that specific malady. The strumous habit of body, with its two varieties of refined and coarse physiognomies, presents us with a soil which is the most favourable of all for the cultivation of the bacilli of tubercle, and for most of the vicious microbes we have knowledge of. A close study of these two distinct habits of body indicates that there is a remarkable antagonism between them. The arthritic diathesis provides the worst possible soil for the tubercle bacillus, which can hardly lodge or develop in it. The scrofulous soil is little friendly to rheumatic infection, and rarely disposed to the morbid metabolisms issuing in gout.

When these two habits of body blend, as often happens, by heredity, we note that the arthritic element in the individual has a marked and valuable influence in restraining the onset of tuberculosis and of inhibiting its progress if it alights on the body. I must add here a note to the effect that I utterly deny the teaching of those who maintain that scrofula is a manifestation of tuberculosis, or,

[1] THE LANCET, August 9th, 1913.

as is sometimes declared, on the authority of Koch, an attenuated tuberculosis. It is possible to be scrofulous throughout a long life without manifesting overt or serious tuberculous disease.

*Heredity.*

Closely allied to this line of thought and experience is the study of the doctrine of heredity, a matter always demanding inquiry, aiding much both in diagnosis and prognosis in every patient. Diathetic proclivities may thus be traced in families, the accentuation of some or the outcome of blended habits being noted in various descendants. We thus gain knowledge which is little likely to issue from scientific or experimental work in the laboratory at the present time. I can conceive a time, however, when the specific qualities of tissue and metabolism pertaining to the subjects of different habits of body may be disclosed to us by biochemical and other researches.

I may mention here that Dr. Nathan Raw, of this city, has lately brought forward important facts which give support to some of these contentions.

THE VALUE OF CLINICAL ACUMEN AND OBSERVATION.

I would illustrate the superiority of clinical acumen to laboratory research by a reference to the teaching of the physiologist in respect of the effects of alcohol as he observes them after proceeding to poison certain small animals with this agent. He declares it to be toxic in any degree for all the tissues of the body. As clinicians we have learned to value it both as a food and a valuable therapeutic aid for certain conditions of disease. We claim no scientific authority for its use, but are convinced of the benefits derived from it when appropriately employed. I suppose that no one is better informed than the physicians as to the effects of misuse of alcohol on the body, and such knowledge makes all prudent practitioners duly careful in prescribing it. I have lived long enough to have witnessed great changes of opinion in this matter from the time when alcohol was largely used, to the present day when its total withdrawal as a remedy is urged upon us. I regard both of these methods as erroneous, and illustrating improper practice. The true physician never sails on any prevalent wave of fashion in therapeutics, but endeavours to see all matters in due proportion, with a level head and vigorous common sense; and when common sense is not combined with clinical practice I am sorry for the patient. I may add on this point that I have yet to learn that any lesions specifically attributable to the use of alcoholic liquors have ever been noted in the necropsies of persons who have led temperate lives, and employed such articles in strict moderation.

While we welcome new methods and post-graduate teaching of them as essential to the progress of medicine and the better equipment of the practitioner, we must acknowledge that in many fields of practice there must be few opportunities of employing them. Hence the value of well-trained observation and clinical acumen which must remain, not seldom, all that can be drawn upon in such circumstances. It is, however, desirable that fresh knowledge should be acquired even by those who are unable to employ it, so that they may urge its benefits on such patients as may be able to secure them elsewhere.

Even in the most favourable environments we do wisely to hold by our clinical skill amidst the temptations of these days to make short cuts in diagnosis, when, without due meditation and patient examinations, we may even defer to make one at all, and proceed at once to arrive at it by securing a direct view of the "living pathology" of our patient somewhere within the recesses of the body. Such a practice is now possible, but it leads to a decay in our clinical art, and it is surely undesirable if not imperatively called for.

We must all regret the injury that has been done to careful clinical study and skill by the National Insurance Act. I would ask, Of what avail is it to provide the best teaching for many of our pupils who cannot by any possibility make proper use of it in the toils of panel practice? The public has little knowledge of the serious blight that has thus fallen upon our profession by this ill-conceived scheme, one that could not have been thrust upon it if it had stood shoulder to shoulder in resisting it, both in the interests of the public and of the honour of the profession.

I need not allude to the value of well-prepared formal clinical lectures, illustrated, when possible, by exemplary cases, but I would urge the importance of holding weekly consultations with the whole staff of physicians on certain patients presenting difficulties in diagnosis. These should be held in a theatre, and the patients examined in the presence of the pupils. The several opinions formed should be declared after the removal of each patient. One of the great advantages of our British clinical teaching is that it brings every student in contact with the patient, and leads him to investigate for himself and take his own notes. Continental teaching does not secure this.

*Evaluation of Therapeutic Methods.*

The new methods of vaccine and serum therapy, and the employment of salvarsan and other powerful agents demand watchful study and large experience of them before we determine their precise and appropriate employment. We have to reckon with impatience on the part of the public which takes note of startling new remedies, and expects an immediate and accurate use of them at our hands.

It is sometimes forgotten that in the matter of treatment clinical observation must always be the final appeal. As declared lately by Professor Chauffard, "it is the physician at the bedside who has the last word to say, and he controls all therapeutical methods, whether old or new. It is by clinical observation alone that the newest acquisitions are to be judged as fruitful or consigned to oblivion."

*The Inherent Vitality of Patients.*

Once more, what an interesting study awaits us in the endeavour to ascertain the degree of inherent vitality in our patients. The varying tissue-resistance of the body is truly remarkable, a personal element in each case. We seek to explain the contrast in the gradual wear and tear of the textures observable in the still-active nonagenarian with that of the obvious senility of some who have not reached far beyond middle life, and who have yet lived prudently. This inherent vitality is a great element to be reckoned with. It is sometimes familial and racial, and is an appanage of the Hebrew race. It materially affects our prognosis in cases of acute and chronic disease. Disregard of this factor probably accounts for more gloomy prognoses than are justifiable, the vital resistance of the individual not having been appreciated. Such condemned patients are occasionally found to provide material for "faith" and "spiritual" healers to exult over and publish to our discredit.

We have lately been reminded by a great clinical authority that "book prognosis" is far removed from the living and actual prognosis applied not to the disease but to the patient.

*The Mental State of the People.*

The modern clinical teacher should take note of the changes which occur in the mental disposition and conduct of his patients as time passes on. We are led to inquire in this connexion if, with what we are pleased to call progressive civilisation, our people are really more brave and patient than were our ancestors of a century ago. I incline to the opinion that the introduction of anæsthetics and numerous anodynes, the pressure, strain, and motorial life of our population may, in varying degree, account for the present phase of tenderness, introspection, impatience, and mawkish sentimentality which is now so prevalent. These conditions certainly modify the symptoms and tend to disturb the treatment of our patients. The clinical laboratory will not help us in dealing with such matters. Our public school doctors now tell us of the "nerviness" of many schoolboys who fail to display the pluck and hardness of their predecessors.

If we take note of these matters it is a duty for us to declare them. They are very manifest, we are told, in the United States of America, and are attributed to similar causes prevailing in large centres. Higher education has not only not averted the onset of these phases, but has probably rather encouraged them. The introduction into our daily press of medical matters with detailed descriptions of diseases, together with vulgar pictures of scenes which it were better not to depict, is having, as I believe, unwholesome effects upon the public, rendering people less courageous and amenable, and vastly more apprehensive when they become patients.

I think we owe a duty to the public in referring to these sources of mischief, and we, happily, can do so apart from all debasing political considerations. You may think that I have wandered from my text in alluding to these conditions now encountered in our patients. On the contrary, they are serious clinical matters, as many of us know well.

THE MODERN TEACHING OF CLINICAL MEDICINE.

To sum up, I will now endeavour to point out what manner of man a modern teacher of clinical medicine should be. We find some new suggestions on this subject in the recent report of the Royal Commissioners on the University of London. These recommend the adoption of the system followed in the great schools of Germany. This, put briefly, presupposes a fully trained physician who should devote his life mainly to teaching, dealing with a sufficiency of hospital in-patients, together with a staff of expert assistants working in a laboratory attached to the wards. The professor is to be debarred to a large extent from entering into any private practice or consulting work.

Such a system would completely overturn our present methods, and several objections to it promptly occur to us. One of these, and an important one, is the limitation of duty mainly to hospital in-patients whose ailments are always the most serious. One of the greatest advantages of our British system is the wider experience to be gained from private practice which is wisely permitted, one which admits of knowledge gained from the study of many morbid conditions which are seldom seen in hospital in-patients. Our well-conducted out-patient departments, of moderate size, with skilled teachers, constitute one of the best sources of experience for all students of medicine. Another objection is the difficulty of finding such men in this country who will be able and ready to forego the emoluments derived from private consultations. In default of this, it would be necessary to have such appointments liberally endowed, and with pensions on retirement, from some source other than the medical school, which has no funds to employ for the purpose. Again, the expert staff of senior men attached to such a professor must also be liberally paid for their services, which should be carried on for some years, as they are in foreign schools, by the same men.

I am prepared to deny the special advantages which are claimed for this system. According to my ideas, it is not clinical teaching in its best sense. It appears to be propounded with the idea that medicine is, or ought to be, an exact science, and hospital patients little else than materials for the laboratory. That is not my outlook in this matter. I maintain that such professors would not be the best instructors for the average student—that is, for the majority of medical pupils; and I go further, and declare that the system now followed in our best British schools produces superior and more useful clinical practitioners than can be found as the products of many of the continental schools. Our teachers have the widest scope for their experience. Their duties demand and receive much time, and in all good schools, regulated by discipline, the best teachers expend much time in their wards. We are told, however, that "the chief object in London medical education is the passing of students through the various examinations." I must beg leave to deny this assertion in respect of the hospital physicians of the London, provincial, and the Scottish schools. I have taught pupils for more than 30 years at the bedside and lectured in a large school of medicine, and I can affirm that the idea of preparing them to pass examinations has never once entered my head; my duty has always been to teach them how to practise their profession with insight and skill and to promote accurate observation of the details, as well as of the greater facts, in evidence, away from all book studies. I must leave the surgeons to speak for themselves in this matter.

*Post-graduate Training.—Chiefs of Clinics.*

So far I have been considering the opportunities available in this country for educating the average practitioner. It has lately been declared in the public press that there are no provisions for aspiring students and for those who have the ambition to fit themselves for the higher position of teachers. Such advantages are certainly not far to seek in our largest schools, and the men we are thinking of may safely be left to avail themselves of them. There are now excellent post-graduate schools and laboratories for research in all our great cities, and colonial and foreign students are making use of them. It is natural and desirable that pioneers such as these should seek inspiration and fresh fields of work in the great continental schools, and learn other methods from their eminent teachers. It must be added that those who conduct such teaching in this country are, as a rule, very inadequately remunerated for their laborious duties. In the continental schools there is provision made for them by Government grants

The public little realise that some of our best hospital teachers are actually contributing out of their earnings towards the compulsory education of students. We do not hear of similar benefits being bestowed in other professions.

I think that it would be an advantage to our system of hospital training if we introduced the foreign one of securing a chief of the clinic to act under each clinical teacher, who should undertake and supervise the research work of the clinical laboratory. These appointments should be made for a term of three years at least, and an adequate stipend should be paid to the occupant. The experts in the laboratory should always endeavour to be in touch with the patients who become subjects for research. Beyond this, I hope that our British schools will not follow further on foreign lines in the endeavour to improve our teaching.

### Concluding Remarks.

I confess to the highest admiration of many of the methods pursued in the Parisian school, for there we find the art of medicine bound up with the best scientific side of it. The great clinicians there have the benefit of the fuller experience of private practice and consulting work, and they certainly devote themselves assiduously to their duties in the wards.

A clinical teacher has great responsibilities. Before all things he must be human and sympathetic, never forgetting that he is dealing with patients who have souls as well as bodies, and not with mere "cases." He has to illustrate and teach good manners as well as medicine. He must believe in his art, for a sceptic in therapeutics can teach nothing. He should not pursue many novelties, for in my experience novelty-hunters have not been well instructed in the principles of medicine in their early career. To these requirements I would add, lastly, a large measure of tact and common sense, no small amount of geniality and humility, and a due degree of such dignity as rightly belongs to men charged with serious duties to their country and their fellow creatures.

## THE TREATMENT OF NEURASTHENIA.[1]

By J. S. RISIEN RUSSELL, M.D. Edin., F.R.C.P. Lond.,

Professor of Clinical Medicine and Physician to University College Hospital; Physician to the National Hospital for the Paralysed and Epileptic, Queen Square.

### *Diagnosis.*

"Neurasthenia" has become as much the refuge of the destitute, when a diagnosis is called for to account for nervous manifestations, as has long been the case with "influenza" when febrile symptoms are under consideration.

There can be no doubt that in many instances the diagnosis is made owing to the kindness of heart of the medical man responsible for it, as, although fully alive to the fact that he is dealing with a case of insanity, in which melancholia, delusional insanity, or some other mental affection is really responsible for the patient's symptoms, he allows himself the licence of labelling the affection "neurasthenia" for the comfort of the relatives and possibly for the peace of mind of the patient after he or she has been restored to health.

An individual who is really suffering from hysteria is similarly commonly said to be affected by "neurasthenia," as hysteria is an ugly word and one that is not usually palatable. Then, again, I need hardly remind you how often some grave organic affection is in the background, underlying the manifestations ascribed to neurasthenia, and how in some instances it is only at the necropsy that the real nature of the affection is ascertained.

Even after we have eliminated all such cases that have no legitimate claim to the diagnosis of neurasthenia we are left with a very large collection of patients whose symptoms are very similar, but with regard to whom it is justifiable to speculate that probably many very different maladies are confused in the present state of our knowledge. We hear so much of colitis, intestinal stasis, and other conditions as giving rise to a group of symptoms that some of us ascribe to neurasthenia that it becomes all-important that we should attempt to determine whether these conditions are the outcome of neurasthenia or whether they are responsible for the symptoms ascribed to neurasthenia. Are we to rely in treatment on measures calculated to raise the tone of the nervous system to effect a cure, or is the remedy to be found in Plombières douches, liquid paraffin, abdominal supports, or possibly evisceration?

*Types of the disease.*—After eliminating all other possibilities and justifying to our satisfaction the diagnosis of neurasthenia, we are next face to face with the fact that there are many different types of this affection, and that it is very necessary to recognise this if treatment is to have any chance of success in a given case. Without multiplying types unnecessarily it will probably be admitted by most of us that the cases fall conveniently into one of three main groups—a cerebral, spinal, and cerebro-spinal—and that the first group may be further conveniently subdivided in view of the fact that in some of the patients the symptoms are physical, whereas in others they are purely psychical, although in many both physical and psychical symptoms obtain.

To justify these contentions I need only briefly remind you of the headache, vertigo, and other purely physical symptoms that belong to one variety of the cerebral type, and of the phobias, obsessions, and other mental symptoms that belong to the other; of the feelings of physical exhaustion, pains in the back, weakness of the legs, and other similar symptoms that belong to the spinal type; and to the cases that constitute the cerebro-spinal type in which cerebral and spinal symptoms obtain in the same individual. Certain it is that these different types must be recognised if neurasthenia is to be treated with any hope of success, and that what may reasonably be relied on to succeed in one type of case cannot possibly be expected to effect good in another.

In addition to all this the nationality and temperament of the individual must be given due weight in our deliberations before we recommend treatment, considerations that are little, if at all, less important than the question as to whether the symptoms indicate a degree of exhaustion of the nervous system in which the tone is very low and in which the senses are blunted, or one in which the nervous system is in a state of undue tension with irritability and hyperacuity of the various senses. To attempt to treat people of all nationalities and temperaments on the same lines is to court failure, and it is equally certain that much in treatment that may benefit the individual with

[1] Being a paper read at the Medical Society of London on Nov. 10th, 1913.

marked loss of tone of the nervous system is not only calculated to do no good in the patient whose nervous system is in a state of over-tension, but that such treatment usually does much harm.

*Causes.*

In neurasthenia, as in other maladies, it is, of course, important to search for the cause, and when this is possible to remove it. It is, however, a mistake to suppose that removal of the cause, when this can be effected, will suffice to bring about a cure, for this is far from the truth. Nevertheless, careful search must be made for any possible cause such as some remote source of septic absorption from the pelvic organs of the female, a chronic appendicitis, pyorrhœa of the gums, &c.; chronic constipation, colitis, and dyspepsia must be corrected, as must all such prejudicial influences as eye-strain and the like. People suffering from this malady usually require active treatment directed towards resting and toning up the nervous system, in addition to the removal of the cause that has been responsible for the condition. I say active treatment for the reason that I am fully satisfied that in the large majority of cases rest and change without active treatment merely result in temporary amelioration of the symptoms, and that without active treatment the majority of patients relapse soon after they return to their normal conditions of life. True as all this is, it is equally certain that the degree of success to be expected from treatment in neurasthenia is largely influenced by the cause that is to be blamed for inducing the condition.

*Prognosis.*

The subjects of neurasthenia commonly regard themselves as suffering from some peculiar malady distinct from anything that has ever affected anyone else, and they are usually most hopeless in regard to the outlook, and so most sceptical as to the chances of a cure. This is, of course, not justified in a large proportion of cases, but in others we know only too well that, although the patient is wrong in supposing that he or she is suffering from any peculiar affection, nevertheless there is unfortunately good ground for the belief that the outlook is hopeless and that no treatment is to be expected to effect a cure.

Of no other class of case of neurasthenia is this more true than of the variety in which an individual is born with the tendency to the affection, and in whom sooner or later the symptoms will appear without any adequate cause that can be assigned, such as undue strain, shock, or any of the ordinarily recognised causes that are known to induce the condition. In this class of case the history is often very similar to that with which we are familiar in "folie circulaire," for periods of exhaustion with depression alternate with periods of feelings of exhilaration and wellbeing, in which there is an exuberance of spirits. Another class of case in which the outlook is far from promising is that in which, either with or without an adequate exciting cause, there is in the background a hereditary neuropathic taint which exercises a profound influence on the patient's illness, and which militates very seriously against the chances of success from treatment.

Despite all this, there remains a very large group of cases of neurasthenia in which a cure is to be confidently expected if the proper treatment can be secured for the patients, and one of the essentials in the treatment is a hopeful outlook as regards the future on the part of the medical man who is prescribing or carrying out the treatment. So much does this mean to every neurasthenic that it is our duty to extend this mercy to all cases of the kind that come under our notice, even if we have reason to fear a contrary result, for the temporary mental comfort and possible alleviation of suffering more than justify this.

*Cases in Children.*

The larger my experience of neurasthenia the more am I convinced that children suffer from this affection, and that many a neurotic wreck that we meet with in after life might have been made very different had his malady been recognised and properly treated in childhood. I recognise very fully how difficult it must be at times to be sure that we are dealing with a genuine case in which lack of nerve tone is responsible for the child's behaviour, as contrasted with laziness or malingering. Nevertheless I am convinced that many a boy is being flogged or otherwise punished to-day in consequence of what is as much an illness as any other malady from which he might be suffering, and it has been my happy privilege to help many such young patients, sometimes in the face of strong opposition from schoolmasters and medical men. More often, however, I am glad to say that no opposition has been placed in my way, although it has been painfully obvious that I have been regarded as a "specialist" with little knowledge of boys and their ways, and thus easily taken in by the lazy boy or girl who feigns symptoms of illness in order to escape from the drudgery of work.

Few things have given me greater pleasure than in one such case in which I was able to send a telegram of congratulations to a boy in consequence of a brilliant athletic achievement for his school, a boy who a year or two before was in a condition in which nothing of the kind would have been possible, but who under appropriate treatment made such an excellent recovery as to enable him to distinguish himself in this way.

When the diagnosis is made in these young people I feel confident that the correct treatment in them is a properly conducted "rest cure." In those who have not yet commenced school life this can be done in the patient's own home, if he or she be properly isolated with a good nurse-masseuse who is thoroughly conversant with the details of the treatment. When, however, the patient is at school the cure ought to be conducted in a good home where the treatment is well understood, and in the case of boys it is all-important to select a home where a resident medical man is at the head of affairs, and where in consequence the boy will not be only under petticoat government. The reasons why we should insist on treatment away from the patient's own home in such cases are too obvious to call for further comment.

*Treatment.*

This leads me to deal with the treatment of neurasthenia in general, and I make no hesitation in at once asserting that in the large majority of cases there is no other method of treatment that offers the same chances of success as the so-called "rest cure," provided it is conducted in a home given up to treatment of the kind, where the atmosphere is impregnated with all that goes to make for success in the treatment, and where the medical man, matron, and nurses all thoroughly understand

such patients and know how to deal with them to their best advantage.

Can it be wondered at that this method of treatment so often fails, and in consequence falls into disgrace, when medical men are content to conduct their "rest cures" in homes where the din and clatter of preparations for operations, the smell of chloroform or ether, the groans of sufferings or other ominous sounds that make it only too evident what is happening, so constantly reach the patient, and where the nurses delight in regaling them with the most gruesome details of the latest operations, or of some "interesting" surgical cases that they have nursed in the past?

Personality plays so important a part in the treatment of neurasthenia that it is highly necessary to secure people who, while sympathetic, have nevertheless sufficient force of character to inspire confidence in the patient. One of the first essentials towards the successful treatment of these cases is complete confidence in the person who has prescribed the cure, and in those who are to carry it out. The person who belittles the neurasthenic, or who scoffs at his symptoms, courts failure in the treatment of the case. The attitude to adopt is that of sympathetic attention to the detailed account of his case, and a judicious question interposed from time to time does good, as does a suggestion that this or that symptom exists, for this naturally allows the sufferer to recognise that the person he is consulting is familiar with the symptoms that are to be expected in a case like his, which proves helpful when the time comes for the medical man to try to convince the patient that he is not suffering from anything peculiar or incurable, but that many hundreds of other people have suffered in a similar fashion and have been cured by appropriate treatment.

Much patience is naturally called for in all this, and it is difficult to conceive a moment when it can be more difficult to exercise such patience than when at the end of a long and tiring interview of the kind, with the hospital to attend, a train to catch, or a peppery practitioner to meet in consultation, the proverbial list is extracted, and consulted so as to allow the patient to make quite sure that he has not omitted to mention any important symptoms. A supreme effort is then necessary, and rather than show in the least that we are in a hurry it is better to ask for a second opportunity of going more fully into so important a case, so as to avoid the risk of failing to gain the confidence of the patient through any show of irritation, if success is to be expected to follow the advice we intend to give in regard to treatment.

In addition to the particular class of cases already referred to in which it commonly happens that no form of treatment proves successful, there are others in which a "rest cure" alone, unaided by certain adjuncts in treatment, cannot be expected to do all that is required in the case. There are other cases in which the temperament of the individual makes it impossible to hope for good from the unmodified method of treatment that bears the name "rest cure," others in which the physical condition of the individual does not warrant the hope of success from this method of treatment, and others again in whom the symptoms are so purely psychical, and the physical condition of the patient so good, that there is no reasonable probability that a "rest cure," no matter how prolonged, will do any real good.

Here it is that "suggestion" finds its most useful place in the treatment of neurasthenia. Whether this method of dealing with a given case is to be recommended alone, or whether it should be combined with other methods of treatment, directed towards building up the tone of the nervous system, must depend on the exact combination of symptoms that obtain and on the physical state of the individual. Happily much of the prejudice against this method of treatment that has existed in the minds of the public and members of the medical profession is being gradually removed, and the rooted conviction that if once a patient gives up his "will power" to a hypnotist he is no longer a free agent, but is doomed to be constantly under the domination of the will of the operator, is fast losing the formidable hold it has had on the minds of people. In consequence of this many a sufferer from phobias and obsessions is able to-day to secure relief from a method of treatment that has been denied to others similarly afflicted in the past, and even to many at the present time.

I must leave it to those specially qualified to speak with authority on such matters to deal more fully with this aspect of our subject, but in so doing I cannot help allowing myself the liberty of questioning how far it is wise to probe too deeply into a forgotten past, and as to whether Freud's method of psycho-analysis has not certain limitations that must be recognised if a method of treatment that can help some is not to bring uncalled-for misery to others.

Massage and the application of faradic electricity form part of the usual routine in the ordinary rest cure, but there are patients who are not helped by massage, as it proves too irritating to them, aggravating all of their symptoms and increasing their insomnia when this happens to be a symptom. What is true of massage is applicable to electricity in a much larger proportion of cases in which this method of treatment proves much too stimulating, and is accordingly calculated to do harm rather than good.

One sees so many cases of neurasthenia in which the patients have been treated by massage without being told to rest in conjunction with this treatment, that a word of warning in this connexion does not appear to be out of place. Massage should be only employed in these patients if an adequate amount of rest can be secured during the course of treatment, as otherwise it is calculated to do harm in the majority of cases. The same does not apply to electricity, which can often be employed to advantage in one form or another without its being necessary to insist on rest in the way that is called for with massage. More than this I do not propose to say about this form of treatment, as there are those who are to take part in the discussion whose special knowledge of this subject will permit of their speaking with a degree of authority that I cannot claim.

Of hydropathic methods the pack and warm bath find a place, especially in the treatment of insomnia; while the needle bath and spinal douche, which are useful in many cases of neurasthenia, are especially so in the sexual and in the spinal forms of the affection.

A useful adjunct, and one which is sometimes successful when employed without any other form of treatment, is spermin, alone or combined with various glands of internal secretion. While useful in all forms of neurasthenia, and especially so where there is loss of sexual power, one or other of these preparations has appeared to be helpful

in rescuing from cerebral softening the neurasthenic of advancing years, in whom there has been reason to suppose that the cerebral vessels have been none too good and have in no small measure been responsible for the calamity that seemed pending.

Drugs must take an entirely secondary place in the treatment of neurasthenia in so far as a cure is to be expected from their use, but certain of them prove helpful in mitigating the sufferings of these individuals. Tonics often do far more harm than good, and a drug like strychnine behaves in much the same way as electricity in many a case of the affection, and is especially to be avoided where insomnia is a prominent symptom. It, however, finds a useful place in the treatment of sexual and of spinal neurasthenia, and may sometimes be employed with advantage in other forms of the malady when judiciously combined with some sedative such as bromide, a drug that we could ill afford to dispense with in the treatment of this affection. Even in spinal neurasthenia, however, the degree of irritability may preclude the use of strychnine and electricity in the treatment.

Provided it is tolerated by the gastro-intestinal tract arsenic is one of the most useful tonics that can be employed in the treatment of these patients, while glycerophosphates, lecithin, phytin, and in some cases iron, all find a place among the medicines that prove helpful in some cases, but the last-named is usually badly borne by the stomach and is apt to increase the tendency to constipation.

All that need be said of hypnotics is that we should avoid their use as far as possible, but that it is better to secure for the patient a good night of sound sleep from time to time rather than allow him to go night after night without any such relief, and that of the various hypnotics that may be tried medinal and trional prove as useful as any, while morphia should be avoided at all costs, although I was once driven to its use most reluctantly, with the best possible results, in a man who was becoming delirious at night after a prolonged period of insomnia unrelieved by every other hypnotic that was tried.

Medicines also prove helpful in correcting dyspepsia and constipation when other measures in treatment, such as diet, massage, and electricity, have failed to do what is required. An alkaline mixture directed towards combating indigestion is a useful adjunct in the treatment of patients who are undergoing a "rest cure," and in addition to any ordinary aperient that may be found necessary to secure a daily action of the bowels, it is well to prescribe for such patients blue pill or calomel once a week, followed by a saline.

The treatment that is to follow a "rest cure" is little less important than the cure itself. Various forms of mental and physical exercises, including walking and other kinds of exercise in the open air, must now be alternated with periods of rest in the recumbent posture, and any such exercise, whether mental or physical, must be taken short of its inducing undue fatigue. The periods of exercise should be gradually lengthened as the periods of rest are curtailed.

Now it is that other methods of dealing with these patients, such as by change of air, sea voyages, and the like, that usually prove failures before active treatment has been carried out, find a useful place in the cure of cases of neurasthenia. In selecting a place for change of air there can be no doubt that the large majority of neurasthenics do far better at inland bracing places than by the sea, although there are those who benefit by residence at the seaside. In the choice of an inland resort due attention must be paid to the fact that where insomnia is a symptom the higher altitudes of mountainous countries like Switzerland are to be avoided, and the same applies when the heart is irritable with a tendency to palpitation.

Wimpole-street, W.

## NOTES ON FOUR CASES OF URETERAL CALCULUS

### IN ONE OF WHICH A COMPLETE CAST OF THE URETER WAS PRESENT.

BY HAROLD COLLINSON, M.S. LOND., F.R.C.S. ENG.,
ASSISTANT SURGEON, LEEDS GENERAL INFIRMARY.

BY improvements in radiography and a more general use of the cystoscope the diagnosis of calculi impacted in the ureter has been simplified and operations for their removal have become increasingly frequent and successful. The number of recorded cases is very large, and little that is new can be said in reference to the methods of operative treatment. I have recently had under my care four cases which present interesting features, one of which I believe is unique as regards the size of the calculus removed, and for that reason I feel that they are worthy of record.

CASE 1. *Calculus impacted in the upper end of the ureter; calculous anuria; nephrotomy.*—The patient, a man aged 40, was admitted to the Leeds Infirmary, under the care of Professor H. Littlewood, on Nov. 10th, 1910. About seven years ago the patient, who had previously enjoyed perfect health, began to be troubled with "gravel stones." He said that during the next five years he passed a stone on the average every six months. Two years ago he was about to be admitted to the infirmary, but two days before he had to come he passed a stone of the size of a pea. From that time until seven weeks ago he was quite well, but then was seized with pain in the left renal region and passed a quantity of blood; he continued to work for a fortnight, but then ceased work and the hæmaturia disappeared. A return to work was followed by a recurrence of the pain and he came to the infirmary. On admission the urine was acid, of specific gravity 1010, with a slight trace of albumin, but no blood. A careful screen examination was made by Dr. L. A. Rowden, the director of the electro-therapeutic department, but no shadow could be detected in either kidney or ureter. No operation was advised, and the man returned home on Nov. 10th. Between that date and Jan. 5th, 1911, he was free from symptoms with the exception of an occasional slight pain in the left loin. On the morning of Jan. 5th he had an acute attack of pain in the left renal area followed by profuse hæmaturia; the same evening he found that he could not pass urine although the pain was much easier. Between that time and his readmission he passed no urine at all.

On readmission on Jan. 7th the patient looked well, the pulse being 72, and the temperature 97·5° F. There had been no vomiting; his mental condition was normal. A catheter withdrew no urine. Various diuretic drugs were tried without result. X ray examination again gave no evidence of calculus in either kidney or ureter. Between the 7th and 10th no urine was passed; there was no vomiting, and with the exception of slight headache he complained of no symptoms. The pulse-rate fell to 60 and the temperature to 97°. Professor Littlewood kindly asked me to see him on the morning of the 10th, and I decided to explore the left kidney.

A lumbar incision was made. The kidney was found to be much hypertrophied, acutely congested, and slightly hydronephrotic. Owing to the risk of lacerating the organ in its acutely congested condition it was thought unwise to attempt to deliver it through the wound, so the pelvis and ureter were explored *in situ* with the finger. A calculus was felt to be

filling the upper end of the ureter and projecting into the pelvis. An incision was made on the convex border of the kidney and a finger passed into the pelvis and the calculus, which was of the shape and slightly larger than a date stone, removed. The kidney was drained by a rubber tube passed through the cortical incision. Within five hours the dressings were soaked with blood-stained urine, and at 10 A.M. next day the patient passed 4 oz. of urine naturally. Urine ceased to leak from the wound in a week, and from that time onward the amount of urine passed varied from 24 oz. to as much as 74 oz. in the 24 hours. Recovery was uneventful.

Chemical examination of a portion of the calculus demonstrated that it was composed of practically pure uric acid and it was almost transparent to the X rays, for a screen examination of the stone placed beneath a thin book scarcely revealed a perceptible shadow.

I was naturally anxious to ascertain the condition of the man's right kidney, but thought that the risk of a cystoscopic examination so soon after a complete suppression was unjustifiable. During December, 1911, however, I sent for him and found that he had been following his employment as a miner for some months with no inconvenience, except occasional backache. He consented to come into the hospital for cystoscopy. The appearances were as follows.

The left ureteral orifice was prominent and slightly patulous, with some reddening of the lips. Within 20 minutes of the injection of 1 drachm of 4 per cent. indigo carmine vigorous and frequent jets of deeply blue-stained urine were being ejected. The right ureteral orifice was narrow and slit-like and almost invisible; an occasional muscular contraction could be seen, but during the 15 minutes it was under observation no jet of urine was detected. The conclusion to be drawn is that the right kidney is almost if not entirely functionless. The urine contained a small quantity of albumin and a few pus cells. Within six hours of the cystoscopy the patient had two smart rigors and his temperature rose to 104°, but he was fortunately quite well again in 48 hours.

The case illustrates in a striking manner the remarkable absence of toxic symptoms in obstructive anuria and a difficulty which may arise in deciding upon which kidney to operate. If the localisation of pain had not been so definite the absence of X ray evidence of calculus would have made the decision extremely difficult, and it might have been necessary to explore both kidneys. In these circumstances the prone position recommended by Deanesly[1] would have been of great convenience. The permeability of the stone to the X rays is a circumstance of much interest, for at least two examinations were made under the best possible conditions and the stone was of considerable size. There is no doubt that in cases with definite clinical symptoms pointing to renal calculus a negative X ray examination even by an expert is not a contraindication to operation, for the stone may be quite impossible to detect by such means.

CASE 2. *Calculous cast occupying the whole length of the ureter; nephrectomy and ureterectomy.*—The patient, a female aged 29, was seen in consultation with Dr. Allan R. Wilson, of Leeds, and Dr. Rowden. A skiagram had been taken by Dr. Rowden. (Fig. 1.) This remarkable picture shows two shadows, one extending from the lower pole of the left kidney to the brim of the true pelvis, and the other from this point to the opening of the ureter into the bladder. Apparently two calculi are present, one articulating with the other at a point where the ureter makes a sharp turn over the pelvic brim. Examination of the right kidney was negative. The patient gave the following history. Her mother told her that at the age of 4 years she had a sudden and violent attack of pain in the left kidney region and that she subsequently passed a quantity of blood; this was followed by similar attacks of pain coming at intervals but not always accompanied by hæmaturia. At the age of 12, as the attacks persisted, an X ray examination was made, and although a calculus was diagnosed no operation was advised. Shortly afterwards she went to Scarborough, and whilst there had a number of attacks with considerable hæmaturia; she was confined to bed for several weeks and was evidently extremely ill. After her return the attacks persisted and she frequently had to be sent home from school on account of pain. At the age of 22 she became a barmaid, and although she often had to lie down and occasionally to return home during an attack she managed to keep her situation. The pain appeared to be typical renal colic, beginning in the kidney region and radiating to the groin, not infrequently accompanied by vomiting and usually followed by more or less hæmaturia. A long walk, hurrying, or prolonged standing would almost always precipitate an attack. So far as she was aware she had never passed a calculus naturally. During the last 12 months she had had several attacks of severe hæmaturia.

FIG. 1.

Skiagram from Case 2 showing calculous cast of left ureter, from behind.

On examination she was seen to be a well-nourished girl, but distinctly anæmic. The left loin was tender, but the kidney was not palpable. In the position of the ureter, however, a hard tumour could be felt; this extended from the renal fossa to the brim of the pelvis, it followed the line of the ureter, was tender on pressure, very hard, and was apparently fixed against the posterior abdominal wall. It appeared to be about the thickness of the thumb, and the surface was smooth. On rectal examination a similar mass could be felt in the termination of the left ureter; its lower extremity was pointed and could be moved slightly from

[1] Brit. Med. Jour., 1911, vol. i., p. 1041.

side to side by the finger. It was evident that we had to deal with a calculus or calculi occupying the whole length of the ureter. The urine was alkaline, and contained a quantity of albumin, pus, and amorphous phosphates. A cystoscopic examination was made 20 minutes after the injection of indigo carmine. The bladder was slightly injected but

FIG. 2.

Photograph of kidney (from Case 2), with portion of ureter and calculus.

otherwise normal; the right ureteral orifice was normal in appearance, and vigorous jets of blue urine were issuing from it. The left ureteral orifice was situated on a mound-like elevation and no blue urine was passed during several minutes, although occasionally a feeble jet of blood could be seen. A ureteral catheter entered without difficulty, but was arrested at a point about half an inch from the orifice. It was evident that the left kidney was secreting little, if any, urine, and that the right was sufficiently healthy to warrant removal of the former if this should be found necessary. I did not think it was wise to catheterise the right ureter on account of the infected state of the bladder.

An operation was performed on March 17th, 1911. The kidney and ureter were exposed retroperitoneally through an incision extending from the costovertebral angle to a point above and in front of the anterior superior spine. The kidney was found to be slightly enlarged and hydronephrotic. No calculi could be felt in it. From a point half an inch below the junction of the ureter with the renal pelvis the former was occupied by what appeared to be a calculous cast; the ureter was therefore isolated to the point at which it crossed the iliac vessels and opened by a longitudinal incision over the upper end of the calculus. This was seized with forceps and a piece 4 inches in length removed without difficulty; the lower end had a fractured surface, and after slightly enlarging the incision a further portion 1 inch in length was removed from the ureter where it lay in front of the iliac artery. This piece had a convex facet on its lower aspect which evidently articulated with the stone filling the pelvic ureter. In order to reach the latter it was necessary slightly to enlarge the parietal incision and to open the ureter just above the pelvic brim, and even then its removal was a matter of considerable difficulty, as the edges of the cup-shaped depression on its upper end were sharp and the posterior margin was hitched beneath the brim in intimate relation to the iliac vessels. The stone was steadied by the pressure of an assistant's finger in the rectum and it was removed in one piece, but the ureter, which was extremely friable, was torn almost across at the site of the incision. It was evident that the kidney and ureter were so much dilated and altered and that so much damage had been done to the latter by the operation that it would be wiser to remove them. The ureter was therefore divided as low down as possible and removed along with the kidney. The lower end was wiped out with pure carbolic acid and dropped back, and a small drainage-tube was passed down to it. Convalescence was quite uneventful and the patient is now well.

Fig. 2 shows the kidney, a portion of the ureter, and the two calculi, beside which a scale in inches has been placed. The upper stone is rather more than 5 inches in length, and the lower 2½ inches. The weight of the first is 840 grains and of the second 440 grains, a total of 1280 grains or 83·2 grammes.

So far as I am able to ascertain from the literature the calculus removed in this case is unique. It really consists of a cast of the ureter extending from the kidney to the point of entry of the ureter into the vesical wall. A section of the lower calculus (Fig. 3) shows at its lower end a small

FIG. 3.

Photograph of section of lower calculus (from Case 2), showing uric acid stone with superimposed deposit of phosphates.

oval uric acid stone which evidently became impacted during the patient's childhood. Above this successive layers of phosphatic material have been deposited from the urine which was able to trickle past the calculus until the ureter was ultimately filled. A similar specimen is figured

by Morris[2] and is in the museum of St. George's Hospital, but this was discovered post mortem.

CASE 3. *Calculus impacted in the iliac portion of the ureter.*—The patient, a man aged 45, was seen in consultation with Dr. L. J. Milne, of Mirfield, in April, 1911. During the past month he had had two attacks of acute pain in the right kidney region shooting down to the groin. These lasted several hours and were followed by slight hæmaturia. Renal calculus was suspected and an X ray examination was made during the first week in May; a shadow of the size of a small bean was seen in the right kidney and was diagnosed as a calculus. As I was going away from home the operation was deferred until June. At the end of May another severe attack occurred and he was sent to the infirmary. On this occasion no shadow could be seen and he returned home in a few days. Four weeks later he had a fourth attack of colic and was readmitted. A screen examination on July 21st was negative, but as the symptoms were so definite and he was quite sure that he had not passed a stone I decided to explore the right kidney.

The operation was performed on July 24th, when a lumbar incision was made. The renal pelvis was slightly dilated, but no calculus could be detected in the substance of the kidney or in the pelvis on palpation. A small incision was made in the cortex and the pelvis explored with the finger; no calculus could be felt. A ureteral bougie was then passed but was arrested above the pelvic brim; the wound was slightly enlarged and the ureter traced down. About half an inch above the point where it crossed the iliac vessels it was found to be obstructed by a small angular calculus of the size of a pea; this was tightly impacted and could not be moved upwards, so the ureter was incised over it at the point of impaction. The wound in the kidney was sutured and the margins of the incision in the ureter brought together by a fine catgut suture. A small rubber drain was passed down to the neighbourhood of the ureteral incision. During the second 24 hours a slight urinous odour was detected in the dressings but quickly disappeared, and recovery was uneventful.

In this case, as in Case 1, X ray examination was negative on two occasions. The first time the patient was screened I myself saw a shadow which I took to be calculus in the kidney, but it was a larger shadow than would be given by the stone removed, and I am certain that no stone was left behind in the kidney at the operation. On the second and third occasions no shadow at all was visible, and it is easy to understand why a small calculus lying at the point from which this was removed should escape detection, for it was lying in front of the thickest portion of the ilium. The case illustrates the necessity for a thorough exploration of the ureter in all operations for renal calculus.

CASE 4. *Calculus impacted in the juxtavesical portion of the ureter; retroperitoneal ureterotomy.*—The patient, a man aged 23, was admitted to the Leeds Infirmary on Oct. 5th, 1911. At the age of 8 years he had a severe attack of renal colic; there was difficulty in micturition during the attack, but no hæmaturia was noted. Between that time and the date of admission he had a large number of similar attacks at varying intervals, and in none of them was there noticeable hæmaturia. The last attack was six weeks before, and on this occasion pain was severe in the hypogastric region and accompanied by cutting pain in the urethra during micturition. His bladder was washed out on two or three occasions with considerable relief. An X ray examination of the kidney showed no calculus, but just above the point where the ureter entered the bladder wall a very distinct shadow was visible. Dr. Rowden kindly took a plate of this for me; it is certainly about the best X ray picture of a ureteral calculus that I have seen. Rectal examination discovered a hard mass in the position of the lower end of the right ureter.

An operation was performed on Oct. 21st. A cystoscopic examination was made 20 minutes after the injection of 1 drachm of 4 per cent. indigo carmine. The left ureteral orifice was normal; vigorous jets of blue urine were issuing. The region of the right ureteral orifice was œdematous and much injected; the orifice could not be identified and no jets of urine were seen to issue during the time of the examination. As I was anxious to know the condition of the kidney the patient was turned upon his side and a lumbar incision made. The pelvis was found to be dilated but not tense; no calculi could be felt. The ureter was dilated to the size of one's little finger, and its walls were much thickened. Evidently the only calculus to be dealt with was the one in the juxtavesical portion of the ureter. To have reached this by extending the lumbar incision would have entailed an extensive division of muscular fibres, so the wound was carefully closed in layers and the patient rolled over on to his back. With the foot of the table slightly raised the usual "gridiron" (McBurney) incision was made as if for the removal of the appendix, but the abdomen was not opened. The peritoneum was stripped from the iliac fossa to the pelvic brim and the ureter isolated; on tracing this down into the pelvis the stone could be felt tightly impacted just at the point of entry into the bladder wall. Efforts "to milk" the calculus upwards were ineffectual until pressure was made upon it by an assistant's finger in the rectum; then careful manipulation succeeded in moving it up about half an inch to a position in which it could be seen and the ureter incised over it. When this was done and the stone removed it was found to be slightly smaller than the shadow in the skiagram and to be covered with projecting spines which were responsible for its immobility. The incision in the ureter was brought together by two catgut stitches of the Lembert type, and a small drain of dental rubber was passed down into the pelvis. For four or five days slight leakage of urine occurred, but at the end of that time it ceased and recovery was uneventful.

In this case, as in Case 2, the history was a long one, and judging from the large size and thickness of the ureter and the character of the stone it is probable that the latter had been lying in the ureter for a number of years. A skiagram of the stone after removal shows a uric acid nucleus with a laminated outer portion. The removal of the stone by the method adopted was not easy, but the difficulties were not nearly so great as one would imagine. If the calculus had not been so tightly impacted and could have been manipulated up the ureter to a point above the pelvic brim its removal would have been extremely simple.

The operative approach to calculi lying in the pelvic portion of the ureter has been the subject of much discussion, and a number of routes have been suggested and most of them practised. Some of these, such as the sacral and parasacral, are unnecessarily difficult and dangerous, and in the male we must make our choice between the following: the perineal, the iliac extraperitoneal, the transperitoneal, or a combination of the last two. The perineal is only applicable to calculi lying in the last inch of the ureter, and has the great disadvantage that only a very limited portion of the duct can be explored, and the calculus is apt to slip away into the dilated ureter above and be lost, an experience which I have had in attempting to remove a stone through the lateral vaginal fornix. It is a method which I should hesitate to adopt. The choice between the extraperitoneal and the transperitoneal routes is a matter of some difficulty. Sinclair White[3] makes a strong appeal for the routine adoption of the transperitoneal operation and records two very successful cases, and to those who are familiar with abdominal surgery this method has much to recommend it. The ease with which the whole length of both ureters can be palpated and the amount of room and good illumination of the operative field afforded must be counted as very great advantages.

[2] Surgical Diseases of the Kidney and Ureter, vol. ii., p. 460.

[3] Brit. Med. Jour., 1910, vol. i., p. 1.

In cases in which the X rays suggest calculi in both ureters or on the opposite side to that to which the clinical symptoms point, a transperitoneal exploration will clear up the diagnosis, and if calculi are present they can be removed with comparative safety by this route. When a calculus is definitely diagnosed to be impacted in the paraischial or juxtavesical segment, and there is no indication to explore the kidney, a muscle-splitting incision such as I have described is the method of choice, and if the stone is difficult of access extraperitoneally a small incision in the peritoneum will allow of the introduction of the finger to manipulate it into a more accessible position or to fix it during its extraperitoneal removal. This combined method has been adopted by J. H. Gibbon [4] in ten cases with excellent results. By this procedure the amount of traumatism is reduced to a minimum. When a calculus in this position is only diagnosed by attempts to pass a ureteral bougie during exploration of the kidney a separate muscle-splitting incision should be used in preference to the usual extension of the original wound with its extensive division of muscles. R. H. J. Swan [5] describes a similar procedure for ureterectomy in tuberculous kidney, and I have myself used it for a similar purpose with great satisfaction.

The advantage of the extraperitoneal incision of the ureter appears to me to be the very small amount of leakage which occurs even though accurate suture of the incision is impossible; as a matter of fact, I believe it is unnecessary in many cases to close the incision at all, and the absence of sutures makes the subsequent development of stricture less likely. If a calculus be arrested in the intramural portion of the ureter and cannot be dislodged by the ureteral catheter or operating cystoscope it should be removed by the transcystic operation.

Leeds.

## THE PRIMARY CAUSE OF RHEUMATOID ARTHRITIS.*

BY H. WARREN CROWE, M.D. OXON.

IN a paper on the etiology of rheumatoid arthritis, published in THE LANCET last May,[1] I described an organism which I had isolated from the urine in a large proportion of cases of rheumatoid arthritis and neuritis, and a further paper complementary to this was published by Dr. A. B. Soltau in the same issue. Though similar in microscopic appearance to the pyogenic staphylococci, there were certain marked points of difference in culture, and of them, the most important for easy distinction was the appearance of the growth on a medium composed of eggs slightly tinted with neutral red. The organism was spoken of under the temporary descriptive name of the staphyloid coccus A. The pyogenic staphylococci produce rose-red colonies which turn to a vivid orange, whereas the colonies of the staphyloid coccus A remain rose-red or become gradually paler. Both produce indentation in the medium. These characteristics—colour and indentation—are diagnostic.

I left two questions open: the first, as to whether this organism was causal or merely casual in rheumatoid arthritis; the second, amongst what group of germs this staphyloid coccus A should properly be classified. This paper is a contribution towards the further elucidation of these two points. To deal with the latter first.

It was first suggested to me by Dr. J. Matthews, of St. Mary's Hospital Inoculation Department, that the germ very probably was one of those which inhabit the human skin, and which were named by Welch [2] the M. epidermidis. This turns out to be the case. The sugar reactions are the same: Broth culture turbid; pigment on agar white; acid and clot in milk; liquefies gelatin slowly; acid formation from action on maltose, lactose, but not mannite, glycerine usually, but not always. The growth on neutral red egg medium is identical and serum reactions are parallel. Fig. 8 shows a series of bloods tested for complement fixation with a typical staphyloid coccus A and a M. epidermidis albus isolated from a self-produced blister on the skin of a girl suffering from hysteria. The broad black bands in the tables indicate complete hæmolysis of sheep's corpuscles, partial hæmolysis being shown by a fainter colouration. These reactions are not exactly parallel, but I think sufficiently so to show that the organisms are closely related. Fig. 1 shows an opsonic curve determined in respect of both organisms. Four specimens of serum were examined—the first before a two-million dose of staphyloid stock vaccine was given, and the second, third, and fourth 12 hours, 24 hours, and 48 hours respectively after the injection. The curves are similar, though not identical. The only difference which I have found to exist between the particular cultures used for these experiments is that the staphyloid coccus A liquefies gelatin at a slower rate than the epidermidis albus.

In order to avoid the further use of such a clumsy expression as the staphyloid coccus A, I wish at once to give the germ what I suggest should be its correct biological title, but for this purpose one must anticipate slightly, and assume the proofs, which I shall immediately put forward, that this organism is the primary cause of rheumatoid arthritis. It would then be appropriate to denominate the microbe as the M. epidermidis, variety deformans, or perhaps, since that is somewhat unwieldy for common use, I may be permitted to allude to it in future under the shorter name of the M. deformans. I would like here to express my great appreciation of Professor R. T. Hewlett's kind assistance in helping me to decide on a proper title.

Permit me now to enter upon the justification of what must, I am certain, seem to be a very great assumption; and to clear the ground, under this term rheumatoid arthritis I would include only those forms of arthritis which present no demonstrable infection of the joints, and which conform more or less strictly to that typical primary polyarticular disease, sometimes called polyarthritis deformans, characterised by fusiform swelling and redness of the joints, frequently symmetrical in character, usually commencing in the fingers, and associated with glossiness of the skin and muscular degenerations and contractures. I expressly exclude rheumatic joints, and all cases of infective arthritis, such as arise as the result of the entry of the gonococcus, pneumococcus, and other germs into the joint itself.

Bacteriologists agree that serum reactions hold a

[4] Annals of Surgery, 1913, p. 232.
[5] Guy's Hospital Reports, vol. lxiv., p. 39.
* A paper read before the Pathological Section of the Royal Society of Medicine on Nov. 18th, 1913.
[1] THE LANCET, May 17th, 1913, p. 1377.
[2] William H. Welch, M.D.: Conditions underlying the Infection of Wounds, American Journal of the Medical Sciences, July-December, 1891.

very important place in proving a causal connexion between a given disease and a given organism. Of these, the complement-fixation reaction is probably the most important. The first four tables give the results of sera tested by this method. The exact technique was as follows. An emulsion of a 24 hours' culture of the M. deformans was standardised and killed by heating at 60° C. for an hour. The sera of Fig. 4 were all freshly drawn and no complement was added. In the rest of the tables all serum was heated for 15 minutes at 60° C. to destroy complement, and then fresh complement in the form of normal human serum was added. Fleming's method was followed. Two volumes of serum, one being that under examination, the other fresh human serum (complement), were run into miniature test tubes, and four volumes of normal saline or the various dilutions of the standardised emulsion respectively added. The mixture was kept at blood heat for 20 minutes, when one volume of 5 per cent. (or in some cases 10 per cent.) washed sheep's corpuscles were stirred into each tube. A reading was taken after a further half to three-quarters of an hour at blood heat. The thick cross line is drawn at that point below which no control blood fails to show hæmolysis. With a view to avoiding all personal bias, Fleet-Surgeon Kilroy kindly performed some independent tests for me without knowledge of the sources of the majority of the sera, and in Figs. 4 and 7 his results are recorded. I must express my very deep sense of gratitude to him for his kind assistance, which was the more valuable on account of his extended experiments in the complement-fixation test, commonly known as the Wassermann reaction for syphilis.

In Fig. 4 it is seen that a very wide series of dilutions were examined. The first blood and the last three were controls from perfectly healthy individuals. The second serum was taken from an extreme case of rheumatoid arthritis; the third also from a case of frank rheumatoid arthritis; the fourth from a patient who had had rheumatic fever and suffered from chronic rheumatism, but had no symptoms whatever of rheumatoid arthritis or neuritis. In Fig. 5 the same emulsion was used, the first and fifth sera being controls. The middle three were each cases of rheumatoid arthritis. Fig. 6 shows some eight cases, in which the reaction was used for diagnosis where an early stage of rheumatoid arthritis was suspected, but the organism was not found in the urine at the first attempt. All suspects were positive with two exceptions; No. 12, in which the symptoms were confined to two joints, and these greatly enlarged by osteophytes. It was, in fact, a case of osteoarthritis, and not necessarily related in any way to rheumatoid arthritis. The opinion has been expressed that the cure of rheumatoid arthritis results in the formation of osteophytes producing a condition of osteoarthritis, but whether this be true, or whether, on the other hand, osteoarthritis and rheumatoid arthritis are different diseases, in either case a negative complement-fixation test was to be expected. The other exception, No. 9, was a very interesting and instructive case. Rheumatoid arthritis in typical form attacked a lad whilst in hospital. The test was performed three weeks after the disease appeared. The result was negative. A month later, however, on testing the blood again, a positive result was obtained (No. 19 of Fig. 7). After a further month, during which the patient had been treated by vaccines of this organism, and when the disease seemed to be fast disappearing, a further test was performed. The result was negative. Fig. 7, one of Fleet-Surgeon Kilroy's, is, I think, extremely convincing. He informs me that Serum No. 1 was taken from a case of acute Bright's disease, whose urine had yielded the M. deformans together with a streptococcus, and the blood was taken after he had regained his health. The result of the test was negative. Sera 2, 3, 4, 15 were normal men; 16, 17, 18, 19, all typical rheumatoid arthritis; 9, a convalescent pneumonia. It will be seen that all the rheumatoid patients gave positive results, and none of the others. Complement-fixation tests, then, afford conclusive evidence that the M. deformans is pathogenic in rheumatoid arthritis.

In the light of these tests, and with the addition of all cases seen up to September last, I am now able to revise the incidence table previously published.[3] Taking all positive tests to indicate that the organism is present and pathogenic, in 26 cases of typical rheumatoid arthritis the organism was present in all. It was cultured in 22 and positive complement-fixation was demonstrated in the remaining four. In a further 14 less severe and doubtful cases of rheumatoid arthritis, the organism occurred in 11, being cultured from 9. If neuritis is included, and for reasons which will shortly appear it seems that neuritis not improbably should be so included, the total number of cases becomes 48, and the incidence 45—that is to say, 93·75 per cent. Streptococci were present in addition to the M. deformans in 21 cases and B. coli in 7. It must not be supposed that the M. deformans never appears in the urine in any other conditions. I have found it in two or three cases of mild septicæmia, occasionally in neurasthenia, and also in rheumatism; among 35 of such cases recently investigated it has appeared 13 times.

I turn now to other serological evidence.

*Agglutination tests.*—These are not very satisfactory. Some cultures seem to give good tests; others not so. A strain with which I was working earlier gave fair agglutination; but my present ones fail to do so. Fig. 9 shows an agglutination series. Nos. 5 and 6 were control bloods; in Nos. 1 and 4 the M. deformans was present; Nos. 2 and 3 were cases of frank rheumatoid arthritis. The same sera were used as for complement-deviation test (Fig. 4). Again the evidence, such as it is, is favourable,

*Opsonic data.*—Figs. 2 and 3 show the opsonic response to a medium dose of a vaccine of the organism during a course of treatment. In both charts a typical immunity curve is developed. The patients suffered from typical rheumatoid arthritis. It is of interest, and, I think, of importance, to note that where a negative phase is seen as in these two charts it is almost invariably associated with increased swelling of the affected joints and marked rigidity. An experimental dose of M. deformans vaccine given to a normal person produced no fluctuation in the index. To use a legal phrase, this completes the evidence for the prosecution of the M. deformans. In order to summarise the facts here mentioned and bring them into line with others, some of which have

[3] THE LANCET, May 17th, 1913, p. 1377.

FIG. 1.

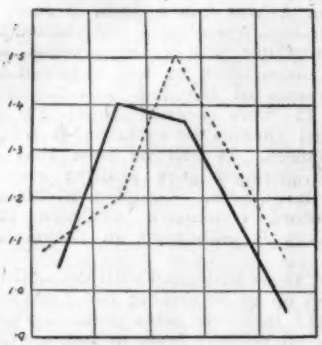


FIG. 2.

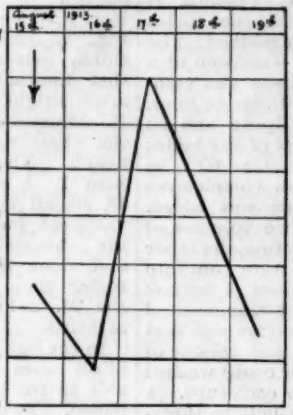
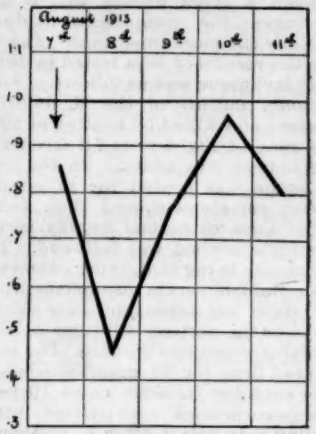



FIG. 3.




already been published elsewhere,[4] I may perhaps be permitted briefly to review the various points in their logical sequence.

Some three years ago, from the blood of a phthisical patient who suddenly developed acute arthritis of the left knee-joint associated with brachial neuritis, I isolated a diplococcus which I have since learnt to recognise as the organism here described—the M. deformans. The case was a remarkable one, for though by no means ill the patient (a young woman of 34) had had for certainly three years previously a raised temperature, which only on the rarest occasions dropped below 100° F. night or morning, and usually remained about 101°. Never had it been found to be normal, though two daily observations had been made during the whole

FIG. 4.

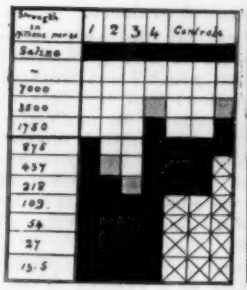
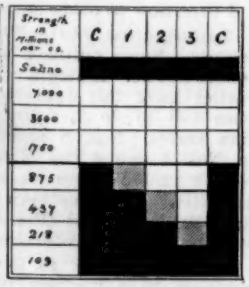



FIG. 5.




of the period. A vaccine prepared from this organism produced remarkable results, in that after a very few doses the knee-joint became well and again serviceable, the neuritis disappeared, and the temperature dropped to normal. It was impossible to avoid the conclusion that this diplococcus was causative of the arthritis, the neuritis, and the fever. A year later, within a week of each other, I had the catheterised urine sent me of two women, both suffering from acute rheumatoid arthritis coming on shortly after parturition. The M. deformans was found in pure culture and in large numbers in both cases, and in both, vaccines of the organism produced that characteristic result, which one always associates with the injection of a vaccine prepared from the organism pathogenic in any given case. About the same time a male rheumatoid patient consulted me. He had a chronic nasal discharge, in which the M. deformans was found. Still more important, it was present in pure culture in the urine. Here, also, the effect of a vaccine was obvious. It was already impossible to dissociate rheumatoid arthritis from the M. deformans.

FIG. 6.

| Name | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nature of Disease | Nasal Blood | | | | A | C | A | A | A | B | B | D |
| Strength of Emulsion in Millions per c.c. of the M. deformans | Saline | | | | | | | | | | | |
| | 1250 | | | | | | | | | | | |
| | 1000 | | | | | | | | | | | |
| | 750 | | | | | | | | | | | |
| | 500 | | | | | | | | | | | |
| Organism found | | | | | − | + | | − | − | + | − | + |
| Result | − | − | − | − | + | + | + | + | − | + | + | − |

A - Typical rheumatoid arthritis.
B - Quasi early rheumatoid arthritis, some stiffness and slight neuritis.
C - Neuritis
D - Osteoarthritis.

These four cases, then, which I have not hitherto described, provided me with the necessary starting-point for systematic investigation. Add now to this the further evidence I have adduced: incidence in the urine, 81·25 per cent., complement-fixation tests, these showing when combined a germ incidence of 93·75 per cent. in all cases of rheumatoid arthritis, obvious or suspected, opsonic data, and finally the clinical response to vaccines; and it becomes almost

[4] Ibid.

impossible to avoid the conclusion that the M. deformans is the actual primary cause of rheumatoid arthritis. I chose the urine as my *materies morbi*, because my conception of rheumatism proper, which is by no means to be confused with rheumatoid arthritis, was based on the fact that the causal streptococci are almost invariably to be found in the urine, without any manifest morbid process in the kidneys, or even urinary symptoms. Presumably rheumatic streptococci are circulating in the blood and excreted by the kidneys. These organisms, too, have been shown to be common inhabitants of the human digestive tract. Obviously these streptococci are not particularly virulent, for the bacteriuria is not associated with any illness

FIG. 7.

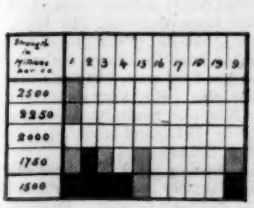
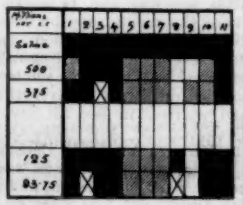



FIG. 8.




The upper dilutions in Fig. 8 are those of the staphylococcus A; the lower dilutions, M. epidermidis albus.

beyond chronic rheumatism. They would, however, possess potential virulence, for from acute rheumatic cases the same organisms have frequently been isolated from the blood, and rheumatic streptococci, whether isolated from the urine of chronic rheumatism or from the blood of acute rheumatic disease, produce the same condition of arthritis in rabbits. If rheumatism, then, is caused by organisms which originated as saprophytes from the bowel, it would seem that such a similar disease as rheumatoid arthritis might also be caused by some common saprophytic and avirulent organism. In both cases the germ would owe its continued existence to the fact of its avirulence; its very innocence would be its protection, and the immunity mechanism unstimulated by such comparatively harmless microbes, would fail to produce sufficient antibodies, or to wage effective war on the insidious invader. And so the germ would multiply and flourish exceedingly, but without much harm to its host, except when its numbers became excessive.

I have already shown that the M. deformans belongs to the M. epidermidis group. Thus rheumatism and rheumatoid arthritis present a parallel pathology, in that the former is caused by a common saprophyte of the bowel, the latter by a common saprophyte of the skin, which gains access to the blood, whence it is excreted or passively filtered through the kidneys, and thus comes to be discharged in the urine.

Apart from various rival germs, which have been described as having been isolated from the joints in certain forms of primary arthritis, confirmation of which is still lacking, there are four important criticisms which may be levelled against my hypothesis. The first is that streptococci, B. coli, and other organisms have been found in local foci of infection in cases of rheumatoid arthritis, and that treatment by vaccines of such organisms has been known not infrequently to cure the arthritis. It is this experience mainly which has given rise to the supposition that primary rheumatoid arthritis has not a definite single bacterial cause, but may be produced as the result of the activities of different germs. I do not propose to combat this by direct denial, nor do I anticipate shipwreck on the point. I merely put forward the suggestion that my hypothesis is by no means disproved because it may be shown that other mischievous germs are at work. I have frequently found them myself, and have been convinced of their pathogenicity. My claim is that these organisms constitute a mixed secondary infection. An analogy will place the matter in a clear light. Let us suppose that the tubercle bacillus had never been discovered. In the present state of bacteriology and vaccine therapeutics, what would be the inevitable conclusion? That the organisms found in the sputum were the cause of the condition: streptococci, B. influenzæ, M. catarrhalis, pneumococci; any of these alone, or in combination, would be supposed to be capable of causing phthisis, as we know it, and it is equally certain that some cases of phthisis treated by vaccines of these organisms would be reported as cured. This is exactly what has happened in the case of rheumatoid arthritis, and I submit that such evidence has really no bearing whatever on the hypothesis that there is a primary causal organism in this disease.

The second criticism might well be that this organism has not been found in the diseased joints. It is a more formidable objection. But since no organism of any kind has been found in the tissues of the affected joints, with the exception of some few cases, which do not seem to have a general application, and of which confirmation is lacking, this criticism would equally apply to any organism put forward as the cause of the disease. The

FIG. 9.

| | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| 1/100 | + | + | + | + | + | +/− |
| 1/30 | + | + | + | + | +/− | +/− |
| 1/200 | + | + | + | + | +/− | +/− |
| 1/300 | +/− | + | + | +/− | − | − |
| 1/600 | +/− | + | + | +/− | − | − |
| 1/600 | − | +/− | +/− | +/− | · | − |
| 1/900 | − | +/− | +/− | − | · | − |
| 1/1200 | − | +/− | +/− | − | · | − |
| 1/1800 | − | +/− | +/− | − | − | − |
| 1/2400 | − | − | − | − | · | − |
| S | − | − | − | − | − | − |

M. deformans, however, is so easily stained and recognised that there is little likelihood of its presence having been overlooked in the joint tissues, and the difficulty is very real. The following facts, however, indicate a possible explanation: (1) I submit that a very large proportion of cases of rheumatoid arthritis, if not all, are either preceded by or associated with neuritis; (2) the joint lesions have been considered to be trophic lesions; (3) the M. deformans occurs with remarkable frequency in the urine in cases of neuritis (of 8 cases it was present in all), and from the incidence

and from serum tests carried out on the same lines as above one is impelled to the conclusion that neuritis (excluding perhaps toxic forms) and rheumatoid arthritis are one and the same disease, both produced primarily by the organism which I have described, though frequently complicated by infections with other pathogenic germs; and (4) spinal lesions have frequently been described in cases of rheumatoid arthritis.[6] Further investigations are required, but they should be directed either towards searching for the M. deformans in some portion of the nervous system or towards demonstrating the presence of some nerve toxin produced by it. It will now be plain why I include neuritis in the incidence table.

Again, it may be objected that the M. deformans may play merely a similar rôle to the M. neoformans in cancer; that one is only dealing with a secondary infection, and that the primary cause is still to be sought. It is conceivable, but seems to me unnecessary, to invoke such complexity for the etiology of rheumatoid arthritis. Cancer differs in that the M. neoformans hypothesis is obviously insufficient by itself to explain the disease. Streptococci are, I think, accepted now as sufficient in themselves to produce rheumatism, and why not the M. deformans to produce rheumatoid arthritis?

Lastly, a plaint may be lodged that no animal experiments have been done. I regret it, but facilities have been lacking, and I thought it needless to defer my communication on that account. All the facts were remarkably favourable, so that they seemed sufficient in themselves to prove my hypothesis, and further, with the advent of serum reactions, than which no evidence can be more convincing, the necessity for fulfilling Koch's postulates in their entirety before assuming the microbial cause of a disease has somewhat diminished. On the first opportunity, however, the attempt will be made.

In conclusion, then, I would describe rheumatoid arthritis as a disease caused primarily by a common inhabitant of the skin, the micrococcus epidermidis, variety deformans, or more shortly, the micrococcus deformans, and I would further suggest that the germ produces the disorder mainly by its action on some portion of the nervous system, and lastly that other pathogenic germs are frequently actively engaged as a secondary mixed infection.

My best thanks are due to Fleet-Surgeon L. Kilroy and Professor Hewlett, whose assistance I have already acknowledged, and to all those medical men who have been instrumental in supplying me with material for this investigation, amongst whom I should like to mention more particularly Dr. A. B. Soltau, of Plymouth.

Yelverton, Devon.

[6] A bibliography of the subject will be found in the paper read before the Cambridge Medical Society on March 6th, 1908, by P. W. Latham, M.D.

LITERARY INTELLIGENCE.—Messrs. J. and A. Churchill announce new editions of the following: "The Diseases of Children," by Sir James Goodhart and Dr. G. F. Still (tenth edition, revised); "A Short Practice of Midwifery for Nurses," by Dr. Henry Jellett, master of the Rotunda Hospital, Dublin (fourth edition, revised); and "Lectures on Medicine to Nurses," by Dr. Herbert E. Cuff, late medical superintendent of the North-Eastern Fever Hospital, London (sixth edition).

# A CASE OF TUMOUR OF THE PITUITARY BODY.

BY A. L. TAYLOR, B.Sc., M.B. EDIN., M.R.C.P. EDIN.,
ASSISTANT MEDICAL OFFICER, DERBY BOROUGH ASYLUM.

THERE are in the following case features which, I believe, justify its publication in the columns of THE LANCET.

The patient, a married woman, over 40 years of age, first came under observation in 1908 on account of mental symptoms. These at first consisted of apathy, with loss of memory and emotional reaction. An ophthalmoscopic examination at this time revealed nothing abnormal, and there was no complaint of headache or vomiting; the mental state would not allow of the fields of vision being tested. Frequent incontinence of urine and fæces was present, due probably to the mental indifference. In December, 1908, she was sent to the Derby County Asylum, and while there the mental apathy became more profound. In April, 1909, she was tried at home again, but did not improve, and had several fits indistinguishable from ordinary epileptic seizures. All this time she took her food well, but remained totally indifferent to everything else, being very somnolent and staying in bed all day. She was readmitted to the Derby County Asylum in October, 1911, and transferred to the Borough Asylum in December, 1911.

On admission here she was a woman aged 48, of middle height, dark complexion, and satisfactory general nutrition; the hands and feet were small and well formed. Physical examination revealed a mitral presystolic murmur, somewhat myotic pupils with a sluggish light reaction, dull flexor plantar reflexes, ordinary knee-jerks, and no diminution of the pain sense so far as could be made out. The urine beyond being rather concentrated showed no abnormal features. The mental condition was one of apathetic dementia with inability to answer any but the very simplest questions, and complete indifference to the passage of the evacuations; she complained of no pain; she resented greatly any attempt to examine her eyes, so that ophthalmoscopy was not possible, but she certainly suffered from marked dimness of vision, as evinced by her manner of eating and going about. This became more pronounced from month to month. On her admission there was no physical sign of paralysis or paresis, and she was able to walk quite well. Her mental symptoms became more accentuated, and in March and April she had two fits with bilateral convulsions. About this time weakness of the right hand showed itself, and she also had several mild attacks of painless vomiting. On June 1st, 1912, she was noticed to become even more drowsy than usual, and in the evening passed into a series of fits, 15 of which succeeded one another without return of consciousness. She remained comatose with very stertorous breathing, and died in the middle of the following day.

*Necropsy.*—On removing the calvarium, which was markedly increased in thickness and density, especially in the frontal region, the following evidence of extreme cerebral compression was noted: The dura was very tense, the subdural space practically obliterated, and the superficial convolutions perfectly flattened out. On removing the brain an ovoid tumour was seen in the centre of the anterior cranial fossa; it measured 4·5 cm. transversely and 6 cm. antero-posteriorly, was firmly attached to the sella turcica, and less so to the cribriform plate of the ethmoid. The surface was somewhat nodular and the consistence firm, the growth being quite circumscribed, and only exerting pressure on the adjacent parts. (See Fig. 1.) A deep hollow was thus present on the base of the brain extending from the posterior perforated spot to the frontal pole, and being widest midway between these two points. The floor of the hollow consisted of the flattened convolutions of the mesial and inferior surfaces of the frontal lobes, the optic chiasma and the olfactory tracts and lobes not being distinguishable. Sections of the hardened brain showed that the cavities of the lateral and third ventricles were almost absent; the brain was otherwise healthy to the naked eye, and weighed 41½ oz. The tumour was kindly examined by Dr. Ford Robertson, of the Scottish Asylums Laboratory, and proved to be an ordinary spindle-celled sarcoma. (Fig. 2.)

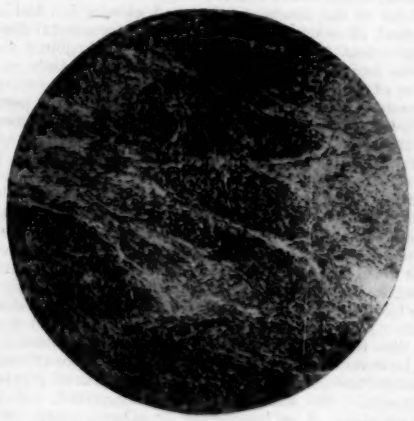
One of the most interesting features of the case is the pressure on the frontal lobes producing very definite and discrete mental symptoms—i.e., gradually increasing apathy and emotional atrophy, ending in profound stupor or dementia. This fact

FIG. 1.

Photograph of floor of cranium showing tumour of pituitary body.

agrees with the current theory that the frontal cortex is the seat of the higher intellectual and emotional processes. One finds a record of a very similar case[1] in which there were no fits, the only

FIG. 2.



Microphotograph of sarcoma of pituitary body.

symptoms being amaurosis and progressive intellectual impairment. A case of sarcoma of the infundibulum[2] of a much more malignant nature than the above occurred in this asylum three years ago; there were epileptic fits, and the mental state was acute excitement followed by stupor. The presence or absence of fits in these cases may only be a matter of individual susceptibility. The three cases mentioned are excellent examples of tumours growing from the pituitary without any dystrophic symptoms.

I should like to thank Dr. G. Bruce, of Melbourne, Derbyshire, for information as to the early history, Dr. W. Ford Robertson for his kind assistance, and Dr. S. R. Macphail, medical superintendent of the Derby Borough Asylum, for permission to publish the case.

Derby.

[1] Oresti Sandri, Rivista di Patologia Nervosa e Mentale, vol. xiv., F. 7, 1909.

[2] W. Boyd: THE LANCET, Oct. 15th, 1910, p. 1129.

# Medical Societies.

## ROYAL SOCIETY OF MEDICINE.

### CLINICAL SECTION.

*Exhibition of Clinical Cases.—The Treatment of Syphilis.*

A MEETING of this section was held on Nov. 14th, Mr. CHARTERS J. SYMONDS, the President, being in the chair.

Dr. A. M. GOSSAGE showed a case of Subcutaneous Granulomata. The patient was a girl, aged 3½, who was admitted into hospital on August 12th last for stiffness in the left knee and pain and stiffness in the left wrist. At the age of 2 her mother noticed that the left knee was held stiff and slightly bent so as to make her walk awkwardly. Lately this had been worse, and the child frequently wanted to rest. Three days before admission the left hand was noticed to be doubled up, and she complained of pain in her wrist. No lumps had been noticed in the trunk or head. On admission she was found to be a healthy-looking child. The left wrist was flexed and the dorsum of the left hand was somewhat swollen; anteriorly over the tendons at the wrist there was some reddish discolouration, and there was some thickening under the skin. The child was unable voluntarily to extend the hand and fingers, whilst forcible extension caused pain. There were about 20 subcutaneous nodules, from the size of a millet seed up to a small pea, under the skin of the scalp, neck, and trunk. These were not tender or painful, and the skin moved over them freely, but in some places was slightly discoloured. Those over the scapula moved with the movements of the arm. The swelling in front of the wrist seemed composed of several nodules matted together, but there was also some swelling of the skin itself, and the tendons were involved in the mass. The left knee was apparently normal, and no other abnormality could be found elsewhere. In the night of August 29th there appeared pain and swelling in front of the right wrist, with flexion of the wrist and some swelling in the dorsum of the hand. On examination a precisely similar condition was found to that in the left wrist—i.e., some thickening and discolouration of the skin, and subcutaneous swelling, which appeared to be formed of several nodules matted together, with involvement of the subjacent tendons. On Sept. 16th it was noticed that the right knee was sometimes drawn up, and that the child seemed unable to straighten the leg again, but forcible replacement by the nurse caused no pain, and the knee subsequently seemed normal, and there was no swelling. There was no alteration in the condition until Oct. 3rd, when she was ordered iodide of potassium, 3 grs. three times a day. Since then the tumours had got smaller and many had disappeared, whilst the swelling in front of the wrists had diminished, and the movements of the hands and wrists had become painless and more free. On Sept. 9th two of the tumours were cut out, and were subsequently examined by Dr. R. G. Hebb, who reported as follows. Both tumours were surrounded by a zone of connective tissue in which were reticular histological tubercles with numerous large giant cells. The central areas were filled with some homogeneous substance which was crowded with small cells of irregular shape; also certain bodies somewhat resembling in appearance Charcot-Leyden crystals were demonstrable by the Ziehl-Neelsen method. The nature of the growth was uncertain. No organisms were

discovered. The tumours having been put directly into formalin, no culture could be made from them. The Wassermann and von Pirquet reactions were both negative. Dr. Gossage said that the three probable causes for granulomata of this type were (1) syphilis, (2) tubercle, and (3) sporotrichosis. There was nothing in the family or personal history to suggest syphilis, and with a negative Wassermann reaction this might be excluded. The histological appearances, the rapid improvement with iodide of potassium, and the negative von Pirquet reaction similarly weighed against the diagnosis of tubercle. In the absence of a culture of the organism one could not be certain of the diagnosis of sporotrichosis, but this seemed to be that which was most probably correct. It was to be noticed that there was no tendency for the tumours to break down in the two months before treatment with iodide was commenced.

Mr. W. J. MIDELTON showed two cases of Arthritis Deformans treated by continuous counter-irritation. The first patient was an elderly woman. Sixteen years ago she first noticed rheumatic symptoms; the joints of the fingers, knees, and ankles eventually became markedly swollen up to two years ago in spite of treatment. Severe attacks of sciatica occurred at times. The patient was first seen by Mr. Midelton with a view to treatment two years ago. At that time she was very depressed and in much pain. Salicylates relieved the latter somewhat, but increased the depression. On examination the patient was found to be too thin; all the phalangeal joints were swollen and of the rheumatoid type. The fingers were cyanosed. The knees and ankles showed enlargement of a soft character with little or no bony change. There were soft pads beneath the ligamenta patellæ bulging on each side. The legs were slightly œdematous. There was a fibrous nodule at the back of the proximal phalanx of the left thumb of about the size of a small hazel-nut and very hard. The subcutaneous tissue of the legs was thickened and suggestive of myxœdema. The toes were cyanosed and the nails withered very much, having practically disappeared in several instances. Very few teeth remained; the patient had obviously suffered for many years from pyorrhœa alveolaris, and the teeth had in most instances become so loose as to need extraction. No marked affection of the heart or lungs was found, but the stomach and bowels were thought to be atonic. Treatment by means of continuous counter-irritation was commenced on Sept. 27th, 1911. On Oct. 31st the swelling was gone from the fingers and the tenderness from the feet. Eventually the patient became so well and active that she undertook strenuous work—on her feet all day and out socially at night. She had had slight recurrences from time to time, but the treatment always readily subdued them, and the patient remained well and active. The pads had gone from beneath the patellar ligaments and the nodule from the thumb. She was wearing shoes that had been put aside for years. Her attacks of sciatica were now slight. The toe-nails had grown again. Excessive fatigue contributed more to recurrences than anything. The second patient was a middle-aged woman. Five years ago the ankles swelled; at about the same time she had a "paralytic seizure," the right arm and the left leg and the back of the neck being affected. There was difficulty in moving the head, and much pain. Her walking power gradually returned, but was variable. She suffered from syncopal attacks, with at times actual loss of consciousness lasting two hours. The attacks had increased in severity. All the joints were more or less tender and stiff, but not much swollen. There was loss of muscular power in the knees, their flexion and extension being limited. The right elbow and neck were very tender. A typical rheumatoid condition of the first and second metacarpo-phalangeal joints was present. The skin of four fingers was glossy. The wrists were puffy, but moved fairly well. She was scarcely able to move the head at all, the features being mask-like. The right arm was practically useless. Many of her teeth were out and the remainder were infected at the roots. Treatment by continuous counter-irritation was commenced in February, 1912. The patient had not been out of the house for four months when first seen, and a very gloomy prognosis had been given. The heart had been thought to be in an advanced state of fatty degeneration. Within a very short time after the commencement of treatment by means of counter-irritation the patient greatly improved. She regained power to write, to sew, and to walk up and down stairs easily. The patient had become increasingly active and had practically ceased to have any syncopal attacks; she still had treatment from time to time.

Dr. F. PARKES WEBER showed a case of Rheumatic Nodules associated with Rheumatic Torticollis. The patient, aged 11, was a pale, rather delicate-looking boy, with a certain degree of wry-neck, the neck being bent towards the patient's right with the chin turned a little to the left. There was no arthritis, nor did the boy complain of any pain or tenderness anywhere, but there was some puffiness about the second and third metacarpo-phalangeal joints in both hands, and over these joints very small rheumatic nodules could be seen and felt. There were moderate-sized rheumatic nodules over both elbows and both knees, those over the knees being the largest and the most numerous. The olecranon bursa at both elbows was enlarged. The heart was excitable in action, and the impurity of the first sound at the apex suggested slight endocardial changes at the mitral valve. In the absence of fever the frequency as well as the excitability of the heart's action suggested slight myocardial implication. There was a variable systolic murmur to be heard over the "pulmonary area." Some of the lymphatic glands in the neck were a little enlarged. The history was that the boy enjoyed good health until the present illness commenced on Sept. 13th, 1913, with pain in the left ankle; this joint became swollen on the following day. He was treated by rest in bed and small doses of salicylates. At first there was fever up to between 102° and 103° F. This left him on Sept. 20th, but after the 24th to the middle of October there were occasional evening rises of temperature to about 100°. Since then there had been no fever. The wry-neck appeared at the end of September, and was at first accompanied by a little pain at the lower posterior part of the right side of the neck. The rheumatic nodules were first noticed in the middle of October, at first only on the elbows and knees, later over the hands also. Recently he had been treated with subcutaneous injections of rheumatism phylacogen and with careful massage of the neck. Roentgen ray examination showed no bony change in the neck. The special interest of the present case was the association of the wry-neck with rheumatic nodules and affection of the olecranon bursæ, suggesting that a kind of true "*rheumatic* fibrositis," analogous to that which produced rheumatic nodules over the periosteum and fibrous structures, was the cause of the wry-neck.

Dr. PARKES WEBER also showed a case of Angiokeratoma with Bony Changes. The patient, aged 16, was a physically rather under-grown and under-developed boy, mentally quite normal. His extremities were inclined to be cyanosed, and in winter, since the age of 4, he had suffered severely from chilblains of the hands and feet and ears, which had left a good deal of scarring. Owing to these cicatricial changes the movement in some of the terminal finger-joints and in the toes had become very limited. On the hands were a number of dirty-reddish spots, which were minute warts on angiomatous (telangiectatic) bases; they added a peculiar speckled appearance to the cicatrisation resulting from the chilblains. On the feet, in addition to the scarring of the toes from chilblains, there were a number of large, hard "corns" (keratomata); some of these resembled the callosities which occasionally preceded perforating ulcers. In the Roentgen ray skiagrams of the hands and feet the terminal phalanges of the hands appeared somewhat stunted, and there was slight general rarefaction of all the hand bones; in the feet there was marked deformity of the terminal phalanges, and there was more rarefaction of the bones than in the hands; the distal portion of the terminal phalanx of the left big toe had disappeared, as if by a process of absorption, like that sometimes seen in Raynaud's disease. In spite, however, of the tendency to cyanosis of the extremities the patient had never had any definite attacks of Raynaud's phenomena. The knee-jerks were exaggerated, but there were no signs of syringomyelia or other organic nervous diseases. Nor was there evidence of disease of any of the abdominal or thoracic viscera. The chilblain-like condition ordinarily associated with angiokeratoma of the hands and feet seemed to him insufficient in the present case to account for the bony changes revealed by Roentgen ray examination, and yet there had been no definite attacks of Raynaud's phenomena nor local tuberculous disease to account for them.

Dr. W. ESSEX WYNTER showed a case of Hæmophilia. The

patient, a man aged 22, was admitted to hospital in November, 1913, for hæmaturia. There were four sons, of whom the patient was the youngest, and no daughters. The eldest and second were both alive and well. The third died at the age of 15; he was a bleeder; the patient remembered his once cutting his thumb, which bled for days and led to his being admitted to hospital; he also had, occasionally, swelling of the joints which lasted some weeks. The patient himself, before he was aged 8, partly remembered and had been told that he had frequently painful swellings in the knees which necessitated his staying in bed, but always cleared up eventually. When aged 9 the patient had an attack of hæmaturia, unaccompanied by pain, which kept him in bed 14 days. At the age of 16 he sprained his right elbow-joint slightly; great swelling ensued, associated with pain and limitation of movement lasting 14 days. Frequent similar attacks had occurred since, affecting the elbows, the knees, and the right shoulder. The attacks occurred particularly in the autumn. Two years ago, after the extraction of a tooth, bleeding continued for 14 days. He was admitted to hospital for three days and oozing continued after his discharge. These were specific instances amongst many similar attacks of joint swelling and hæmaturia. The present attack of hæmaturia commenced ten days before admission with slight colouration, which gradually became more intense. The following day there was an attack of pain shooting down to the groin on the right side and lasting half an hour. Swelling of the right elbow commenced a week before admission accompanied by stiffness and some redness, a similar attack having occurred a month previously. When shown the patient was a healthy looking youth with bright complexion and was well nourished. There were some swelling and limitation of movement in the right elbow and ecchymosis of the skin in the outer and flexor aspect. The urine was almost porter-coloured and opaque, specific gravity 1020, acid, and contained albumin corresponding with the blood. Corpuscles were present in quantity. An X ray examination disclosed no stone nor any enlargement of the kidneys. The organs appeared to be quite normal, and apart from the hæmorrhage there was no sign or feeling of illness.

Dr. J. H. DRYSDALE and Mr. G. E. GASK showed a case of Splenic Anæmia; Splenectomy; Hæmatemesis 18 Months after the Operation. The patient, a boy aged 16, was admitted to hospital in December, 1911, for hæmatemesis and enlargement of the spleen. Two years before admission he first noticed a large lump in the left side of the abdomen. Since then he had gradually become paler and had been subject to attacks of giddiness. Four months and again two months before admission he vomited a large amount of blood. On admission the spleen was found to be much enlarged. Red cells, 3,525,000; hæmoglobin, 45 per cent.; colour index, 0·64; poikilocytosis; polychromatophilia present; white cells, 3000; all forms diminished in numbers; a few myelocytes. Wassermann's reaction was negative. In January, 1912, the spleen was excised by Mr. Gask, along with two or three spleniculi. In March: Red cells, 3,900,000; hæmoglobin, 54 per cent.; colour index, 0·7; white cells, 6400; polymorphonuclears, 2816; lymphocytes, 2816; large mononuclears, 678; eosinophiles, 38; and basophiles, 114 per cubic millimetre. He remained in good health till July of this year, when he vomited more than a pint of blood and fainted. He slowly recovered, and in September, after a short fit of coughing, brought up a thick silk ligature. He was readmitted in October. His blood count now was: red cells, 5,400,000; hæmoglobin, 90 per cent.; colour index, 0·83; white cells, 6600; polymorphonuclears, 2574; lymphocytes, 3630; large mononuclears, 99; eosinophiles, 198; and basophiles, 99 per cubic millimetre; no nucleated reds or myelocytes were seen. The red cells showed excessive variations in size and depth of staining reaction. Poikilocytes were numerous; reticulate cells, 1·8 per cent.; fragility: hæmolysis began between 0·45 and 0·4 and was not complete before 0·3. The interest of the case lay in the recurrence of the hæmatemesis 18 months after the removal of the spleen. Patients with splenic anæmia might live for 20 or 30 years without surgical interference, and they died sometimes as the result of operation. If they were to remain liable to attacks of hæmatemesis—which was, after all, their most dangerous symptom after splenectomy had been performed—it raised the question as to how far the operation was advisable. This patient was not cured of his disease, for apart from the attack of hæmatemesis he still had a leucopenia, his polymorphonuclears were only half the proper number, and many of his red cells showed abnormalities. His general condition was certainly improved, but one was precluded from saying that his life was safe from the dangers of splenic anæmia.

Dr. ARTHUR F. HERTZ and Mr. D. W. JOHNSON showed a case of Cervical Rib with marked vascular symptoms in a woman aged 45, and a case of Myatonia Congenita in a boy aged 3½ years.

Mr. C. A. BALLANCE showed a woman, aged 20, whose Facial Paralysis had been treated by facio-hypoglossal anastomosis (end to end) and end-to-end anastomosis of the descendens noni to the hypoglossal.

Mr. W. H. BATTLE showed a case of Microglossia in a child aged 1 year and 5 months.

Dr. ALBERT WILSON read a short paper on the Treatment of Syphilis by Arsacetin and by Excision of the Primary Sore.

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## SECTION OF OBSTETRICS AND GYNÆCOLOGY.

### *Relation of Internal Secretions to Female Characteristics and Functions in Health and Disease.*

A MEETING of this section was held on Nov. 6th, Dr. W. S. A. GRIFFITH, the President, being in the chair.

A special discussion took place on the Relation of the Internal Secretions to the Female Characteristics and Functions in Health and Disease. The paper introducing it, by Dr. W. BLAIR BELL, was distributed beforehand.[1] Allusion was first made to the great advances which have been made during recent years in the science of gynæcology and obstetrics. After pointing out that from a broad standpoint femininity itself is entirely dependent on the internal secretions acting in correlation,[2] Dr. Bell considered the more purely morphological and physiological aspects of the subject. The production of the female characteristics—primary and secondary—was traced to the internal secretions, and facts were quoted in support of the statement made. It was shown, too, how the internal secretions directly and through the general metabolism initiated the genital functions at puberty. By way of illustration the calcium metabolism was described in its bearing on the question under discussion. Next, the maintenance of the female characteristics and functions was dealt with, and experimental evidence was given of the importance of all the internal secretions in effecting this end. The conclusions in regard to the morphological and physiological aspects of the subject were: (1) The development and integrity of the genital organs and their functions are dependent on all the internal secretions, individually or collectively; (2) the removal of any one organ of internal secretion produces changes in the others, and by this means we gain some insight into the existing correlations; and (3) the general metabolism is altered by extirpation of any of these organs; this alteration in the general metabolism affects the genital metabolism. From physiological and morphological investigations the following information has been obtained which may be employed in the solution of clinical problems:—1. Our knowledge of the influence of the internal secretions on the sex characteristics and on the development of the genitalia helps us to understand the pathology of hitherto obscure conditions connected with sex characteristics and the development of the reproductive organs. So, also, can we trace the influence of the internal secretions on the psychology of our patients, for in women femininity is associated with psychical qualities which need not be defined here. These qualities are due to the combined action on the brain cells of the metabolic conditions produced by the feminine organs of internal secretion; and the normal psychical condition is frequently disturbed by pathological conditions of the endocrinous glands. 2. Since we know something of the influence of the internal secretions on normal menstruation we can note the abnormal effects produced in regard to the menstrual function, and conversely we can observe the effects produced on the organs of internal secretion by local derangements of the genital organs. 3. Knowing, also, the part played by the internal

[1] This will be published in full in the Proceedings of the Royal Society of Medicine.

[2] THE LANCET, April 15th, 1913, p. 944.

secretions in the metabolism of pregnancy, we can, in the same way, observe the effects of deviation from the normal. The second part of the introductory paper dealt with pathological and therapeutical considerations. First, derangements in the development of the genital organs and their functions were discussed under the following headings: (1) Imperfect and irregular primary development of the genitalia; and (2) irregular secondary development of the female genitalia and functions. It was shown under the first heading how pseudo-hermaphroditism might be produced, especially by hyperplasia of the suprarenal cortex. And under the second heading it was demonstrated how the onset of puberty (precocious or delayed) was under the influence of the organs of internal secretion. Next, derangements of the fully established female characteristics and functions were discussed. This part of the subject was dealt with at some length, since it was of considerable interest from a clinical point of view. The derangements of the fully developed sexual characteristics first came under notice. Then the derangements of the fully established functions were considered from the points of view of increased and decreased secretion from each special organ. Many clinical phenomena in connexion with menstruation and pregnancy were discussed in detail. The results of experimental investigations of the metabolism of animals after partial or complete removal of the different ductless glands were demonstrated by means of tables; and a series of photo-micrographs were shown to illustrate the structural effects produced on the other organs of internal secretion after the partial or complete removal of one of the members of the endocrinous system.

Dr. LOUISE MCILROY, who had been specially invited to continue the discussion,[2] considered the subject under the following headings:—1. The importance of comparisons between the results of experimental work upon laboratory animals and clinical observations—examples. 2. The influence of the internal secretory organs upon development. 3. The constituents of the ovary and their function. 4. The necessity for clinical records upon the effects of oöphorectomy before puberty, during reproductive life, and during pregnancy. 5. The effects of oöphorectomy alone as compared with oöphorectory combined with complete hysterectomy; influence of uterine secretion. 6. The clinical aspect of ovarian transplantation. 7. The influence of ovarian secretion upon metabolism, lactation, and the other internal secretory organs. 8. The influence of the internal secretory organs upon disorders of menstruation, with special reference to precocious menstruation, menorrhagia of puberty, and early menopause. 9. The treatment of gynæcological conditions by glandular extracts—examples. 10. The relationship between general toxæmias and derangements of the internal secretory organs. Dr. McIlroy thought it a happy augury for future work that there should be so much collaboration between the laboratory worker and the clinician. Much confusion as to the function of the ductless glands arose from want of proper comparison of the variations in different species of animals and of the human individual. The secretory organs modified sex development, but did not cause the assumption of secondary characteristics, as these will probably be found to be due to cell development in very early embryonic life. The effects of oöphorectomy alone as compared with combined hysterectomy were mentioned, and the influence of the uterine mucosa discussed; the clinical aspect of ovarian transplantation, the influence of ovarian secretion upon metabolism, and upon menstruation in correlation with the other internal secretory organs were brought forward. Treatment of menopausal symptoms by ovarian and mammary extracts, and menorrhagia by pituitary extract by the mouth gave encouraging results. The influence of the thyroid gland upon toxic conditions was a subject of great importance in gynæcological and obstetric conditions.

The two papers led to a very interesting discussion, in which many invited speakers took part. Among those who spoke were the PRESIDENT, Professor F. H. A. MARSHALL, Dr. T. R. ELLIOTT, Mr. JAMES BERRY, Dr. LEONARD WILLIAMS, Dr. R. MURRAY LESLIE, Dr. FLORENCE A. STONEY, Dr. AMAND ROUTH, and Dr. H. R. HARROWER.

Dr. BLAIR BELL replied.

[2] This paper also will be published in full in the Proceedings of the Royal Society of Medicine.

## SECTION OF ANÆSTHETICS.

*Tachycardia during Anæsthesia.—Paroxysmal Tachycardia.—Anoci-Association.*

A MEETING of this section was held on Nov. 7th, Dr. J. BLUMFELD, the President, being in the chair.

Dr. A. L. FLEMMING gave particulars of a case of extraordinary Tachycardia during Anæsthesia. The patient was a healthy girl, aged 12, undergoing radical cure for hernia. Her heart was normal. The pulse-rate, noted before operation, was 84. No alkaloids had been given previously. Anæsthesia was normally induced with open ether. Five minutes later, after operation had been commenced but before any traction had been made on the sac, the pulse-rate was noticed to have increased to 274. The patient was apparently well; anæsthesia was moderate, and there was no cyanosis. Later the pulse-rate was 288. A change was made to chloroform and then back to ether without any alteration of the pulse-rate. The operation lasted about 30 minutes. Ten minutes after the operation there was some retching, the pulse-rate being 264. The patient was then turned on to her left side, whem the pulse almost immediately dropped to 84.

Dr. W. BEZLY THORNE related the occurrence of Paroxysmal Tachycardia, lasting from four to six seconds, intermitting with a pulse-rate of 80, in a case of strangulated hernia in a patient suffering with aortic regurgitation and aneurysm of the common carotid artery. Preliminary doses of morphia and atropine were given; infiltration of novocaine and adrenalin, followed by chloroform at the operation. The tachycardia occurred the day after operation. Dr. Thorne also mentioned a case of tachycardia in which pressure over the præcordium had given relief.

A paper by Mr. J. H. CHALDECOTT was read (in his absence) by Mr. BRYAN on Some Impressions of Anoci-Association. He briefly described Dr. Crile's method [1]—viz., the hypodermic administration of morphia, atropine, and scopolamine previous to the operation; the employment of nitrous oxide and oxygen as a general anæsthetic; and, lastly, blocking of nerve channels by infiltration of the tissues with solutions of novocaine, urea, and quinine. He pointed out that the nitrous oxide was only used to keep the patient unconscious, and that for surgical anæsthesia one had to rely on the infiltration, any insufficiency of which would not be masked by the nitrous oxide. The chief difficulties of administration were in the early stages, especially if the patient had to be moved or lifted, and also during rough manipulations, and from the presence of gauze packings, &c., of the abdomen. Hewitt's apparatus was used; no rebreathing was permitted. With an experience of 60 cases his results had been very encouraging, unpleasant after-effects being insignificant, except in a few cases. He thought that a good trial of the method would prove it of great value, especially in bad cases.

Mr. C. W. G. BRYAN read a communication on Some Points in the Technique of Anoci-Association (Crile). The injection of local analgesics, he said, was to overcome the evils of shock, cyanosis, and rigidity under nitrous oxide and oxygen. He agreed with Crile that success largely depended upon the local injections and not upon increasing the depth of anæsthesia. Deep general anæsthesia merely masked the trauma inflicted on the patient's nervous system, and with this method painful manipulations were at once made manifest by cyanosis and rigidity. The injection should be made rapidly with pressure, into the various layers, before incision. Abdominal wall infiltration was sufficient where there was not much dragging on viscera. For complicated and deeper manipulations, retroperitoneal and mesenteric infiltrations would be necessary. Difficulty from cyanosis and rigidity was experienced in gastro-enterostomies and operations in the left upper part of the abdomen. Probably injections in the region of the cœliac axis would block sensations from most of the abdominal viscera.—A discussion followed in which the PRESIDENT, Dr. MAY DICKINSON BERRY, Mr. C. CARTER BRAINE, and others took part.

Mr. R. E. APPERLY gave a demonstration of a new Ether Junker Inhaler for nose and throat work.

[1] THE LANCET, July 5th, 1913, p. 7.

## SECTION OF LARYNGOLOGY.

*Exhibition of Cases and Specimens.*

A MEETING of this section was held on Nov. 7th, Dr. D. R. PATERSON, the President (introduced by Mr. HERBERT TILLEY, the retiring President), being in the chair.

The PRESIDENT exhibited the following: (1) A Piece of Button removed from the Left Bronchus; (2) A Piece of Mutton Bone impacted in the Right Bronchus; and (3) A Feather, six inches long, removed from the Trachea and Right Bronchus.—The discussion was chiefly confined to the variations in symptoms produced by foreign bodies in the air passages and to methods adopted for their removal, and was taken part in by Mr. F. H. WESTMACOTT, Dr. G. W. HILL, Dr. W. JOBSON HORNE, Mr. C. W. HOPE, Dr. H. J. DAVIS, Mr. H. LAMBERT LACK, Mr. W. G. HOWARTH, Dr. J. DONELAN, and Sir STCLAIR THOMSON, the last named remarking that the mortality from foreign bodies in the air passages, which was formerly as high as 60 per cent., had dropped to about 1 to 3 per cent. since the introduction of the improved methods of treatment.

Mr. TILLEY: The removal of a Green-pea from the Right Bronchus by an improvised method.

Dr. P. WATSON-WILLIAMS read notes of a case of Cerebro-spinal Rhinorrhœa, with subsequent Sinusitis; operation; death.

Dr. DAN MCKENZIE: Endothelioma of the Ethmoid, which showed no sign of recurrence six months after removal by operation.

Mr. W. M. MOLLISON: A case of Epithelioma of the Floor of the Mouth and Tongue, and Ulceration of Soft Palate.—Mr. TILLEY drew attention to the tendency of chronic ulceration of the mouth becoming malignant.—Mr. P. R. W. DE SANTI, Mr. W. D. HARMER, and Mr. H. CLAYTON FOX also discussed the case.

Mr. PHILIP TURNER and Mr. MOLLISON: A case of Pneumococcal Infection of the Mouth and Pharynx.—Mr. TURNER remarked on the great improvement of the case without the aid of vaccine treatment.

Mr. THOMAS GUTHRIE: Tumour of the Palate (microscopical specimen).—The PRESIDENT remarked on the similarity between the structure of the specimen and that of the mucous glands found in the palate of the rat.

Dr. DONELAN: A case of Double Paralysis of the Superior Laryngeal Nerves of a patient in the course of disseminated sclerosis from lead poisoning.

Mr. T. B. LAYTON: (1) Fixed Crico-arytenoid Joint; phthisis; healed tertiary syphilis; and (2) Mass attached to the Laryngeal Wall.—The PRESIDENT suggested that this was due to prolapse of the ventricle.

Mr. LAYTON also showed a Tumour of the Right Vocal Cord.—Varying opinions were expressed as to whether the case was one of pachydermia or fibroma laryngis.

Mr. WESTMACOTT: 1. New pattern Knife and Cartilage Scissors with Specimens removed by them from cases of deviated septa. 2. Specimens from successive cases of Tonsils enucleated by Matthieu's guillotine. 3. Flexible Rubber Finger Guard.

Mr. H. A. KISCH: The Rhinomanometer.—The PRESIDENT remarked on the difficulty of maintaining the nasal cavities undisturbed during the use of this kind of instrument.

Dr. DAVIS: 1. A case of Minute Growth (? fibroma) on the Left Vocal Cord. 2. Skiagram of a Farthing in the Œsophagus of a Baby aged 2 years. 3. Fixation of the Right Vocal Cord, producing no symptoms, in a man aged 61. 4. Skiagram of a Face showing Arrested Development of the Lower Jaw.

Dr. J. DUNDAS GRANT: A case of small Tuberculous Ulcer localised at the anterior part of the left aryepiglottic fold.

Mr. HARMER: Perforation of the Septum Nasi causing Inspiratory Whistle.

Mr. DE SANTI: Case of Epithelioma of the Epiglottis with malignant glands in the neck after operation in March, 1913.

Mr. J. H. CONNOLLY: A boy, aged 5 years, with a large Pulsating Vessel in the right portion of the Posterior Pharyngeal Wall.

## MEDICAL SOCIETY OF LONDON.

*The Treatment of Neurasthenia.*

A MEETING of this society was held on Nov. 10th, Sir DAVID FERRIER, the President, being in the chair.

Dr. J. S. RISIEN RUSSELL opened a discussion on the Treatment of Neurasthenia. His paper will be found in full on p. 1453 of this issue.

Dr. JAMES TAYLOR said that before endeavouring to deal with the subject of the treatment of neurasthenia he would like to state the conception which he had of this as a disease. The name was so convenient that he at least was, he knew, sometimes inclined to pigeon-hole under it a good many cases which perhaps did not properly belong there. So he had endeavoured to classify for his own satisfaction the cases which, in his opinion, were properly regarded as really neurasthenic. He had been forced, as the result of experience, to the conclusion that they had frequently to deal with a neurasthenic temperament—not really a disease. He thought they were all familiar with the temperament. It was characterised by over-anxiety and apprehensiveness as to any action contemplated, or the effects of it when performed. The subjects of it were very introspective, and what one might call their "mental refraction" was quite erroneous. They were often extremely ignorant of the simplest physiological facts, and had all kinds of curious notions as to the functions and arrangements of the internal organs. In many instances they were sexually vicious, but he could not satisfy himself that this was an inevitable accompaniment of the neurasthenic temperament. Those in the room who were students in Edinburgh 25 years ago or more would remember how often in the medical wards there were, as patients, men from the Orkney and Shetland Isles. They were usually physically sound, of characteristic Norse appearance, yet acutely miserable in a negative kind of way, and in spite of their profound religiousness "without God and without hope in the world." They had no energy, they were full of vague discomforts, and they imagined all kinds of visceral anomalies—that food did them no good because it remained for days in the stomach, that it did not nourish them because it passed unchanged, and so on. These patients did not develop any real mental disease, and they usually left the hospital in the same state in which they came. He had only seen one hospital case of this "morbus orcadensis" in London, actually from the remote islands. All these were characteristic cases of what he would venture to call the neurasthenic temperament. No doubt the cases usually seen of this temperament were more sophisticated. They had a greater command of words, but he ventured to think that their description of their condition, although more articulate, was not less vague. He had been much interested to learn from American text-books that in America the immigrant Scandinavian was regarded as more prone to neurasthenia than most. As to treatment in this condition, he believed it was almost always inefficacious, although a few symptoms might be relieved. As to what he would venture to call induced neurasthenia he was inclined to think that in the vast majority of cases it was the result of hard physical strain, combined with anxiety or unsympathetic environment or uncongenial work. Notorious examples were that of a devoted daughter of a poor physique nursing her mother whom illness had made querulous and exacting; a man of too fine fibre for the rough and tumble and insincerity of politics whose conscientious attendance at dull and unsatisfactory debates had broken down his physical resistance; the over-worked doctor whom anxieties and worries about patients, and perhaps some personal difficulties about money matters, had exhausted in regard to his physical stamina and deprived of sufficient sleep and recreation. Even worse was the clergyman, often young, whose emotional temperament had been tried by the various demands upon it, and whose reason had been more or less outraged by the attempt to swallow dogmas which no reasonable man could digest. *Apropos* of this he thought it was almost worth quoting a remark of one who was not only a literary man but also a doctor, Oliver Wendell Holmes:—

Stupidity often saves a man from going mad. We frequently see persons in insane hospitals who went there in consequence of what are called religious mental disturbances. I confess that I think better of

them than of many who hold the same notions, and keep their wits and appear to enjoy life very well outside of the asylums. Any decent person ought to go mad if he really holds such or such opinions. It is very much to his discredit in every point of view if he does not.

All these patients suffered from similar physical conditions—they were easily tired, they were irritable, they slept badly, they suffered from headaches (often worse in the morning), and they also complained usually of backache. In these cases also the question of sexual influence often arose. In many cases he felt sure it was a part, in many it was not. Medical treatment of all such cases must in his opinion follow similar lines. They must be removed from their work because it had got to dominate them like a nightmare. They must be put under totally different surroundings and kept away from anything likely to excite the old feelings of helplessness and almost despair. He did not think that the ordinary rest cure was at all suitable for the great majority of such cases. Complete isolation often intensified the trouble; each case must be tackled as a separate problem, and the conditions as far as possible chosen which were likely to favour recovery. He could not deny that in most cases rest in bed for at least a part of the day with massage and electrical treatment were good, but he did not think that practitioners ought to be satisfied with prescribing this. They ought to see that the rest of the day was filled up with appropriate recreation, and if the patient was so ill as to need the whole day in bed then they must see to it that he was not allowed to brood, and that isolation was not thrust upon him to his undoing. It was impossible to enter into the details of such treatment because, as he had said, each case must be tackled as an individual problem. In regard to drugs he pinned his faith for the most part to sedatives and stimulants, of which bromide and strychnia were the types, and he was convinced that those drugs judiciously used in such cases could not do anything but good.

Dr. T. B. HYSLOP said that the term "neurasthenia" had been gradually extended in its connotation to include so many types of psychoneurosis that it was exceedingly difficult to lay down any one line of treatment which might be of benefit to anything but the minority of cases. The extension of the term had already—as had been the case with regard to the term "general paralysis"—led to much confusion of ideas with regard to diagnosis and treatment. As a small contribution to Dr. Risien Russell's valuable and instructive paper he would refer to neurasthenia merely from a mechanical and nutritional point of view. Assuming that the more immediate cause of the neurasthenic syndromes is alteration in nutrition—and therefore function—of the cortical cells, it might be of some value fully to consider the conditions on which adequate nutrition and exercise of function were dependent. It should be recognised that the cranium and its contents were dependent upon the blood for its nutrition and repair, and that the processes of nutrition and repair were dependent not only upon an adequate mechanism of arterial supply, but also upon an adequate mechanism of venous drainage. The cranium and the pelvis held a somewhat similar relationship to the general circulation, and their contents were dependent respectively on similar conditions of arterial supply and venous drainage. That being the case, and recognising the close similarity between the two departments, it became evident how, under certain mechanical defects in the circulation, a double series of phenomena became manifest. It was an old observation that congestion of the pelvic contents is apt to be simulated in the brain, as evidenced by the nervous and mental symptoms associated with constipation. The comparison could be carried still further so as to include, on the one hand, the numerous troubles arising from congestion of the various pelvic viscera, and, on the other hand, the almost innumerable varieties of symptoms arising from delay of the venous return not only from the various orifices of the skull, but also from the cerebral convolutions themselves. Such conditions as hæmorrhoids, which were extrapelvic in site, were simulated by the various conditions of extracranial congestion occurring at the orifices of egress of the cerebral and cranial veins, either singly or in relationship to the cranial nerves and the special organs of sense. It would readily occur to all present how, under conditions of lowered blood pressure, a tendency to venous stasis might readily occur, and, viewed from the purely mechanical standpoint, the indications for treatment were evident. In his Croonian lectures on the Degeneration of the Neurone (1900) Mott made some extremely valuable observations in regard to the part played by venous congestion in the production of various forms of nervous and mental diseases. He there pointed out the means whereby a vicious circle becomes established by conditions which tend, on the one hand, to perpetual venous congestion in certain regions, and, on the other hand, to increased excitability of the neurones, these factors mutually interacting. It seemed to be a remarkable fact, that whereas much attention had been paid to the question of the arterial supply to the brain, the venous drainage from the various convolutions had been somewhat neglected. This was all the more remarkable in view of the close relationship between the veins and their surface of drainage from the various convolutions. When one considered the question of the vital importance of an effective drainage from the various sensory and motor regions it became difficult to avoid recognising that many of the groups of symptoms met with in neurasthenia were not only of localising value, but also formed indications as to the treatment necessary. He thought, however, that this was not the occasion further to elaborate the observations of Mott with regard to the part played by venous congestion regarded from a regional point of view, but he believed that the time was not very far distant when many of the types of neurasthenia would come to be regarded as being due to local conditions of a mechanical nature, and dependent upon factors which were entirely extracranial in origin. The tendency to perpetual venous congestion in certain regions, referred to by Mott, was markedly exemplified in some parts of the course of the superior longitudinal sinus and in the area drained by the great anastomotic vein of Trolard. Just as the left middle cerebral artery was the artery of greatest wear and tear, so certain veins were subjected to greater exercise of function than others, and it was to the efficient drainage from these veins that more attention might with benefit be given. Speaking generally, he might state, with some degree of truth, that oftentimes what had come to be regarded as a familial neurotic taint was merely a familial defect in the bodily mechanism, whereby individual members of the family, whilst possessing finely evolved brains, were prone to neurasthenia because their brains were but imperfectly served by the bodily mechanism. The practical indications for the treatment of such cases were very clearly defined, and he had found benefit to accrue from complete rest of the areas which were drained defectively. One general principle of treatment was to increase the force of the arterial wave by cardiac stimulation, and to favour the venous return by aiding the inspiratory venous suction by forced inspiration, *plus* passive pressure or massage, extending from the occiput downwards. Abdominal massage was also of considerable value, and more especially so when it served to stimulate intestinal peristalsis. With regard to the special senses, he would give only one example of the effects of treatment by complete rest. The temporo-sphenoidal convolutions were particularly prone to suffer from venous stasis, and in order to give them complete and absolute rest, and more especially when auditory disturbances were present, he recommended for that purpose plugging of the meatuses by suitably devised plugs of paraffin wax. By this method he had afforded relief from hallucinations of long standing. Time would not permit him to discuss the relative values of the various methods adopted to overcome or neutralise the effects of toxins generated within the body, although, in his opinion, such considerations must in most cases go hand in hand with those to which he had already so briefly alluded.

Dr. T. GRAINGER STEWART said that he would like to associate himself with Dr. Taylor and Dr. Hyslop in expressing his appreciation of Dr. Risien Russell's paper. He would have felt happier had Dr. Russell defined what he included under the term "neurasthenia." It was true that they all understood what was implied by the term, but it was none the less difficult to define it. Those who had attempted to do so had either made their definition so wide that it included mental disorders entirely distinct from neurasthenia, but of which neurasthenia was a symptom, or, on the other hand, had so limited it as to exclude those cases in which neurasthenia had become grafted on to some distinct physical disorder. The most limited definition was that which had described neurasthenia as a primary fatigue neurosis, and if this were accepted it would of necessity imply that in all cases neurasthenia was an acquired neurosis. Personally, he preferred to use the term neurasthenia to denote a mental and physical state characterised

by symptoms, some objective, others subjective, arising in association with many different conditions, mental and physical, but independent of any recognised lesion of the nervous system. It was not, he thought, justifiable in the present state of their knowledge to consider neurasthenia as a disease—the different ways in which it might originate, the variations in its manifestations, and the totally different methods of treatment which might result in its cure all pointed to its being a state of mind and body rather than a definite disease. In treating neurasthenia, therefore, they could recognise it as a condition, not as a disease—a condition which might develop in association with grave mental or physical disease or with minor or functional disturbances in the mental or physical health of the patient. He did not consider that it could ever be held to be purely physical and rarely, if ever, purely mental, but in order to classify the types of neurasthenia they were obliged to fall back upon what, as far as could be determined, was the primary cause in each case. This might only be discovered after the most prolonged and careful examination, and such examination was necessary, not only to find out the cause of the neurasthenia, but even more to give the patient that confidence in his medical attendant without which all treatment might prove unavailing. Investigation would reveal cases which arose from (1) physical disease, exhaustion, or functional disorder; (2) mental disorder or fatigue associated with anxiety or worry; and (3) trauma with or without evidence of physical injury. Although neurasthenia might originate in physical or mental disease, or exhaustion, or from trauma, it was never complete until an element of doubt or apprehension became added to the original symptoms. The patient who had some physical disorder might suffer from exhaustion or fatigue and from loss of brain power without being neurasthenic. Similarly, in cases of overwork the patient was conscious that he could not work so well as formerly, that work was more difficult, and he might experience a sense of fulness or pressure in the head and yet not suffer from neurasthenia. In traumatic cases hysterical symptoms might be present immediately after the injury, but neurasthenia rarely developed within from three to six weeks. In all these instances the neurasthenia arose when the element of doubt began to fix itself in the patient's mind; fear that he might not recover his health; that his mind was giving way. Such apprehensions might at first be almost unconscious, but became more insistent, and as a rule the patient kept them to himself until obliged to seek relief by confiding in his medical attendant or his friends. In order to render treatment efficacious it would not suffice merely to cure or remedy the physical condition; in addition to that, the patient must be made to understand that the symptoms he complained of were due directly or indirectly to some definite cause, and that with its removal they would disappear sooner or later, as the case might be, and that he would regain his normal state. Such an explanation would only be possible or acceptable if the examination had been as complete as even the patient desired. The medical practitioner had to deal with neurasthenia in its early stages often at a time when it was impossible to tell whether the symptoms were indications of some grave disorder or not. In such instances he might not in his own mind have decided as to the nature of the case, and few people possessed the gift of dissembling their doubts from an anxious patient. For this reason it seemed to the speaker that the specialist had an advantage over the general practitioner in treating such cases. He came into the case at a time when the diagnosis might be quite simple, he had the benefit of the practitioner's experience and knowledge of the mental and physical state of the patient, and had the opportunity of making a prolonged and careful examination, and, finally, of expressing an opinion which the patient was more or less prepared to accept with confidence. It would be superfluous to attempt to add anything to the excellent and comprehensive summary which Dr. Risien Russell had given them as to the indications for the various forms of treatment to be adopted in different cases, but whatever method might be adopted he felt sure that the secret of success lay chiefly in gaining the confidence of the patient and in disclosing to him what was the actual cause of the symptoms in his special case.

Mr. DONALD J. ARMOUR said that his object in intervening in the discussion on the treatment of neurasthenia was to draw attention to, and to lay stress upon, the necessity for a fuller and more rigid treatment in the early stages of those surgical conditions which, when not so treated, were, as a late result, such a prolific cause of neurasthenia. And on this account his remarks, strictly speaking, had more to do with the prophylactic treatment than with treatment proper. In his experience there was a widespread lack of appreciation amongst medical men of the necessity of treating head injuries, especially those apparently slight in extent, rigidly and for a sufficient length of time from the occurrence of the accident, if the patient was to be prevented from developing later into a neurasthenic. Indeed, it would be obvious that the milder forms of head injury might in the end have graver results than the severe cases, inasmuch as the latter would, by the very nature of their grave symptoms, demand and obtain a more rigidly enforced treatment from the very beginning. And it was the milder forms, especially if unconsciousness had been completely absent or only transient, which owing to the slightness of the symptoms were either treated for too short a time or even escaped treatment altogether. In such cases the subsequent development of neurasthenia was undoubtedly due either to neglect of all treatment or more often to the failure to continue proper treatment long enough. Too much stress could not be laid upon the necessity for immediate and continued treatment in this class of case if complete recovery was to be obtained. Incomplete recovery sooner or later spelt neurasthenia, and a neurasthenia of a most chronic and intractable type. It was no part of this discussion to enter in detail into the treatment of such injuries. His object would have been obtained if he had impressed upon his hearers how important it was to recognise that every case of head injury, however slight, if insufficiently treated, became certainly a case of neurasthenia before a year was out.

Dr. LEONARD G. GUTHRIE spoke of neurasthenia in early life. He believed the condition was far more frequently innate than acquired. The term neurasthenia implied not only readily induced exhaustion, but also supersensitiveness to stimuli and excessive reactions thereto. Mental, emotional, and even physical development depended upon stimuli derived from the external world and conveyed through the organs of sight, hearing, taste, smell, and touch to our brains, and also to a less extent upon stimuli originating in our internal selves. An individual born bereft of all capacity to appreciate and react to stimuli would be but an inert mass of protoplasm. All individuals varied in respect to this capacity, and the neurasthenic varied in the direction of excess. The neurasthenic child showed intolerance of sights, sounds, tastes, and smells which the normal child endured with equanimity. Hyperæsthesia on the physical side was shown by exaggerated reflexes, tics, spasms, tremors, and convulsions induced by trivial causes, and by abnormal severity of symptoms attending simple ailments. Hyperæsthesia was shown by cutaneous irritability, by the ease with which emotions were aroused, and by an excess of "feeling tone," pleasurable or otherwise, induced by "negative stimuli." In all cases hyperæsthesia and excessive reactions to stimuli led to fatigue and prostration. Neurasthenia had no known pathology, but probably depended upon cortico-thalamic derangement, for it had been shown that lesions which cut off the thalamus from cortical control were attended by emotional hyperæsthesia and excess of "feeling tone" on the affected side. The rôle of the sympathetic was important, for the experience of emotions was entirely dependent upon its action, and hardly any symptoms of neurasthenia and hysteria were unassociated with sympathetic disturbance. In regard to treatment hypersensitiveness could be mitigated, though it could not be annihilated. There was a difference between keeping a neurotic child in cotton-wool and allowing him unlimited opportunities of exhausting himself mentally and physically by expenditure of energy. One was usually consulted on account of the neurasthenia itself and not on account of the excitability and irritability of temperament which gave rise to exhaustion. Rest for mind and body was essential, but in order to secure it tact and ingenuity were required on the part of the physician and the patient's relatives.

Dr. MAURICE B. WRIGHT said that his own contribution towards this discussion would be a very brief consideration of the mental factor in cases of neurasthenia and the possibility of the alleviation of the condition by any method of

psychotherapy. There could be no question that, running parallel to the general functional asthenia, there was evidence in almost every case of a disturbance of the higher psychical centres, disorders of memory, of attention, of concentration, and of will, and, most important of all, a marked emotional disturbance or of the affective states—a diminution of the power of feeling pleasure in any direction, an increase in the range and depth of the depressing emotions. After everything had been done from the physical side to restore a patient to health, there was often a residuum of mental symptoms which could only be dealt with by definite psychotherapeutic procedures. True neurasthenia was hardly ever suggestible to any great extent, but, apart from suggestion in the passive or hypnoidal state, he believed much could be done by steady, methodical mental re-education, education of attentive control and of interest, and perhaps, above all, by a steady painstaking explanation of the importance of such factors as expectancy and disordered attention to bodily functions and sensations, in the production of the various sensations and physical and mental disabilities. The various phobias and obsessions were often superadded to the neurasthenic syndromes, and although he did not personally believe that they had the same etiology as pure neurasthenia, they very often complicated the disease and rendered treatment more difficult. It was in the treatment of phobias and obsessions that psychotherapy in its widest sense more particularly applied. Suggestion in the hypnotic or hypnoidal state might, he thought, be employed with success in many cases, but in addition there should be a careful, painstaking endeavour to find out the causes in the psychological history of the patient which had tended to produce the phobia or obsession. He could not agree with Freud that it was necessary to go back to infantile sexual trends, but be believed firmly that there had been some *vera causa* for every phobia and obsession in the past mental experience of the patient, a *vera causa* which, if only we could demonstrate it to the patient, would enable him to free himself of the mental pain and distress of obsessional ideas. The anxiety states must, he thought, be differentiated from neurasthenia, although they might complicate the disease. In the consideration of this condition he agreed entirely with the Freudian school. In all true anxiety neuroses that he had seen the etiological factor had been apparently some abnormality of sexual life. Suggestion might be of service in these cases, but he thought the main line of attack should be in endeavouring to get the patient to return to a healthy *vita sexualis*.

Mr. A. G. BUCHANAN said that he had been extremely interested in Dr. Risien Russell's illuminating paper. He had had the privilege of treating a good many cases of neurasthenia in conjunction with Dr. Russell; he was happy to say with very satisfactory results. Neurasthenia was a psychical disorder, often with physical symptoms; it was essential to understand what the immediate psychical defect was if we were to cure the disease, and then to deal with it by every means in our power. First and foremost, it must be our endeavour to gain the patient's complete confidence, otherwise the task would be hopeless. The psychic treatment consisted in the following four methods of procedure.

1. *The method of persuasion.*—Persuading the patient that he was curable, that his disorder was purely functional, that there was a time ahead when he would be completely well again, that he must have faith and patience, and not be discouraged at the relapses which mark the course of the disease.

2. *The method of re-education.*—Teaching the patient to control his mental activities. To accomplish this various mental exercises were employed.

3. *The method of suggestion in the hypnoidal or subwaking state.*—Dr Boris Sidis, who first described this method, said: "The attention must be fixed, but it must be distracted from the suggestion; there must be monotony of impression, limitation of voluntary movements, and consequently a limitation of the field of consciousness." Dr. Sidis ascribed a special therapeutic value to the hypnoidal state apart from the suggestibility which characterises it. "It depended on the fact that through the hypnoidal state access is gained to the stores of potential subconscious reserve energy, which by a liberation of energy bring about a reassociation and synthesis of the dissociated mental systems underlying the symptoms of the disease, and the therapeutic value of the hypnoidal state consisted in the liberation of reserve energy requisite for the synthesis of the dissociated systems."

The theory of reserve energy was of the utmost importance to abnormal psychology; it was first advanced by Dr. Sidis and Professor James, and it seemed to form the very foundation of psychopathology and psychotherapy. Far less energy was utilised by the individual than there was actually at his disposal. The energy that was in use might be regarded as the kinetic energy, while the energy stored away was the potential reserve energy. Sir George Savage said that neurasthenia depended to a great extent, if not entirely, on faulty association of ideas. The reserve energy released during the hypnoidal state would assist in the restoration of normal associations.

4. *The method of psycho-analysis*, as described by Professor Freud.—When the psychic tension was due to a submerged factor this method was of great value to bring that factor to light.

According to Professor Münsterberg, neurasthenia is certainly the classical ground for the psychotherapist. Concerning the patient's headache, insomnia, his capricious worries and absurd phobias, his obsessions and fixed ideas, all might yield to the appeal to the subconscious. Undoubtedly these cases were amongst the most difficult one had to treat, owing most probably to their lack of concentration and their powerful auto-suggestions. A noticeable feature was their varying susceptibility from day to day—in some cases even from hour to hour. He ventured to say that in combining psychic with physical methods we should obtain the most rapid and permanent results possible in a large number of cases.

The discussion was adjourned until Nov. 17th, when it was continued by Dr. JAMES MENNELL, Dr. CLAUD FOTHERGILL, Dr. S. A. K. WILSON, Dr. W. P. S. BRANSON, Mr. ERNEST CLARKE, Dr. G. E. SHUTTLEWORTH, Dr. CURTIS WEBB, and Sir DAVID FERRIER, the President. The report of the adjourned meeting will be published next week.

## HARVEIAN SOCIETY OF LONDON.

*Fractures about the Elbow-joint.—Peculiar Characteristics of Tuberculous Sputa.*

A MEETING of this society was held on Nov. 6th, Dr. LEONARD G. GUTHRIE being in the chair.

Mr. ERIC G. GAUNTLETT read a paper on Fractures about the Elbow-joint, dealing chiefly with those of the lower end of the humerus. He pointed out the difficulties in diagnosis between the various conditions and the modern views as to the treatment of such fractures. He divided fractures around the elbow-joint into those affecting the lower end of the humerus, of which the transverse supracondyloid, the T or Y shaped intercondyloid, fracture of either condyle, and separation of the epiphysis, were the most important, and those affecting the radius or ulna, amongst which fractures of the olecranon, coronoid, and the head of the radius were commonest. Accurate diagnosis being of the greatest importance, in children particularly, general anæsthesia was often necessary, while skiagraphy, although useful in cases with obvious displacement, might be misleading in less serious injuries. Diagnosis depended on an accurate comparison of the two limbs, with special regard to the position of bony points, measurements, and abnormal mobility The different varieties of these fractures were then discussed in detail, and the conclusion was reached that all these fractures, with the exception of those affecting the olecranon, were best treated by full flexion. Operation interference was seldom called for, except in the case of those T-shaped fractures involving the joint. Massage should be commenced early and passive movement at the end of the first week, but it should be gentle so as to avoid all unnecessary movements of the fragments. Finally, all doubtful injuries to the elbow in children suggesting an injury to the epiphysis were best treated in this manner, although the physical signs might be indefinite. The paper was illustrated with an excellent series of X ray photographs of the injuries before and after treatment.

Dr. PERCY B. RIDGE read a paper on the Peculiar

Characteristics of Tuberculous Sputa, based on research work carried out in upwards of 2000 cases, in which the albumin content and the cytological aspect had been obtained in each case. From this investigation he was able to draw conclusions, helpful both in the diagnosis and prognosis of tuberculous lesions of the lung.

## EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

*Valedictory Address.—The Suprarenal Glands.*

THE first meeting of the ninety-third session of this society was held on Nov. 5th.

The retiring President, Mr. J. M. COTTERILL, delivered a valedictory address. He alluded to the number of papers communicated to the society, to the four interesting discussions on vaccine therapy, treatment of simple fractures, malingering, and intestinal toxæmia which had taken place, and to the generally satisfactory state of affairs which the society presented. He also spoke in feeling terms of those members who had died during the preceding two sessions.

Dr. A. NINIAN BRUCE gave a communication on the Suprarenal Glands, their Comparative Anatomy, Physiology, Pathology, and Relation to Clinical Medicine. He said that during the past few years enormous strides had been made in many departments of experimental medicine. It had shown that the word "parasyphilis" had no meaning, and that general paralysis was merely another name for syphilitic encephalitis. More recently they had learnt of the discovery of the micro-organism of poliomyelitis and of hydrophobia, but amongst all these subjects there was none which had a greater interest in clinical medicine than that of the internal secreting glands. Until now the true significance and importance of these glands had been recognised by few. It was known that in certain diseases they were involved, but what the nature of this change was, how it had arisen, and how the clinical symptoms were related to it was only vaguely understood. Much that had been written about the suprarenal glands was visionary and without real value. They required a sifting of the good from that which was hypothetical and not yet proved to be good. The great factor in regard to the internal secreting glands was that until now they had rather regarded all the important functions as owing their primary origin to the nervous system. Now it was found that these functions were really chemical in their origin, that the nervous system merely controlled them, that the initial force behind them was a chemical one, and that these chemical substances were formed in the internal secreting glands, which thus assumed an importance that had not previously been sufficiently recognised. Dr. Bruce said that he and others had been working upon the suprarenal glands for four years, and that their knowledge was beginning to take a definite shape. After narrating the anatomical details and alluding to the work of various observers he said that the two fundamental tissues (medulla and cortex) were present in all vertebrates, and therefore were component parts of the vertebrate body. The full significance of these two different portions was brought out when it was discovered that these two parts were completely separated in the fish and formed separate organs. In the fish between the two kidneys two well-defined organs were found, which apparently took the place of the suprarenal bodies. On section they consisted of one kind of tissue only—viz., columnar cells containing fat (i.e., comparable to the cortex only of man). These were known as the "interrenal bodies" and contained no medullary tissue. The medullary portion was represented by a number of small paired bodies lying along each side of the vertebral column and in close relation to the sympathetic ganglia. These were known as adrenal bodies. In the amphibia (frog) the suprarenal glands were in the form of golden yellow streaks upon the surface of the kidney and consisted of columns of cells lying side by side, some of which were cortical and some medullary. In birds these two layers interlaced with one another. The fact that the cortex and the medulla represented two distinct organs was still further emphasised by their development. The medulla was derived from ectoderm, the cortex from mesoderm. The latter was developed from the same cells which gave rise to the reproductive organs, with which they seemed to have some relationship, as cortical tumours had been found in certain malformations of the reproductive organs. The structure of the medulla was so obviously secretory that the conclusion must be arrived at that these cells gave rise to a secretion. The only difficulty was that there was no duct present. Later it was pointed out that, though the suprarenal glands were such small organs, they were extraordinarily well supplied with blood-vessels, no less than three different arteries, and still later it was suggested by Professor (now Sir) E. A. Schäfer that the secretion found its way into the circulation by passing into the blood directly. This suggestion had since been abundantly proved, the secretory cells actually lying close to the walls of the blood-vessels into which the secretion could easily pass. The effect of this secretion was tried on animals by making extracts of the crushed gland in normal saline fluid. If a small quantity were injected into the vein of a rabbit or cat it was found that there was an immediate and sudden rise in the blood pressure. The maximum pressure was reached in a few seconds and the return to normal was almost equally rapid. The rise in pressure varied with the amount of adrenalin injected to a most remarkable degree. So exact was this reaction that they were able to measure the actual amount of adrenalin present in a solution or in a gland by this method. This rise in pressure was due to constriction of the blood-vessels, adrenalin did not act upon either the nerve cell or the nerve fibre, because if the fibre be cut and allowed to degenerate the action of adrenalin was unimpaired. If one paralysed the nerve ending by various drugs this completely prevented the action. The action, therefore, was upon the myoneural or neuromuscular junction. Repeated injections of adrenalin always elicited similar and equal rises of pressure. This sudden rise and fall was a purely artificial result, and the great rapidity with which the reaction passed off showed how rapidly adrenalin was used up. The reaction might be greatly prolonged by injecting the solution intramuscularly or intraspinously, when the absorption was slower and its effects more gradual. If the solution of adrenalin were very weak and were allowed to pass in very slowly a slight rise in pressure was obtained, which persisted and was constant as long as the weak solution was flowing in. If the rate of inflow were slightly increased, the blood pressure rose in correspondence and fell if the rate were reduced. The degree of contraction —i.e., the "tone" of the vessels—was proportional to the amount of adrenalin which passed into the circulation. The cells of the medullary part of the gland were typically secretory and were set vertically around the vascular spaces, which appeared to be, not true capillaries, but sinusoidal. The secretion was manufactured, not as granules, but in a fluid form and passed directly into the blood stream, affecting all the sympathetic myoneural junctions, whether in the vessels or elsewhere. The peculiar function of its action was its stimulation of plain muscle and gland cells which were, or had been, in functional union with sympathetic nerve fibres. In all vertebrates the reaction of any plain muscle to adrenalin was similar to that following excitation of the sympathetic visceral nerves supplying that muscle. In default of sympathetic innervation plain muscle was indifferent to adrenalin. A positive reaction to adrenalin was a proof of the existence and nature of sympathetic nerves in any organ. Sympathetic nerve cells with their fibres and the contractile muscle fibres themselves were not stimulated by adrenalin. Adrenalin would cause relaxation of the intestine and contraction of the sphincters, or *vice versâ*, according to the condition at the time in the same way as nervous impulses did. Addison's disease was characterised by an exaggeration of the normal pigmentation of the skin, extreme prostration, muscular and cardio-vascular asthenia, and a liability to syncope, nausea, and vomiting. After alluding to the work of Addison and Wilks, Dr. Bruce said that it was not until the investigations of Schäfer and Oliver and the recognition of the internal secretions that any exact knowledge of the nature of the lesion became known. The more chronic form of the disease was rare; the average age was 31 years. It had not been proved to be more frequent in tuberculous families or to be hereditary. It was most often associated with tuberculous disease of the suprarenal capsules, which might exist alone or along with tuberculosis of other organs. Addison himself took a broad view of the relation of

symptoms to the lesions, and declared that any morbid lesion of the suprarenal glands might produce the same result, and that these depended not so much on the nature of the organic change as upon the interruption of some special function of these organs. Sir Samuel Wilks thought that only tuberculous lesions could cause the disease. It was now known that any lesion of these glands might cause this condition. The clinical recognition of Addison's disease depended mostly on the presence of pigmentation. Generally speaking, it was not of itself apart from constitutional symptoms sufficient to warrant a positive diagnosis. The average duration of life was 18 months. Without pigmentation the disease was difficult to diagnose. Dr. Bruce described some acute cases —e.g., one which died 11 days after the onset of acute symptoms; another after only two and a half days. Certain cases did not really differ from what occurred in diphtheritic toxæmia. They were both acute and resulted from suprarenal inadequacy. Any acute infectious disease might exhaust these glands. Suprarenal insufficiency must be regarded as a factor of the greatest importance in disease and usually complicated most diseases. The form called Addison's disease was merely the most chronic form of this condition, which formed a long series from the sudden death in diphtheria which has so puzzled investigators to understand. In many infective conditions sudden death was liable to occur often when the patient was convalescent. The disease had produced a certain amount of suprarenal insufficiency, and the patient had been allowed to exert himself before these glands had completely recovered their functional activity. The extra exertion had completely exhausted them and so led to cardio-vascular paresis. This insufficiency might be slow and chronic, and was usually fatal, as might happen in gradual destruction of the suprarenal tissue. Other diseases such as typhoid did not seem to exhaust these glands so rapidly as diphtheria, though they did throw an enormous strain on these glands which might account for the slow convalescence. Dr. Bruce had found records of cases of true Addison's disease which had followed a long convalescence after typhoid, and in which no tuberculous lesions were found in these glands. This might also explain the extraordinary feeling of uselessness which so often followed on influenza. This disease was often associated with cardiac changes; dilatation of the ventricle was by no means rare, and any strain thrown upon the suprarenal glands at this time was surely the utmost folly. This point was of great interest to the surgeon. A long-continued operation might produce complete exhaustion of an already partially exhausted gland. The removal of part of the thyroid gland for exophthalmic goitre was sometimes followed by sudden death. Now, disease of one internal secreting gland might lead to involvement of others. Excessive thyroid secretion did not lower blood pressure, and yet cases of this disease were found in which there were low blood pressure and pigmentation. These were cases in which the suprarenal glands were becoming affected through probably nervous exhaustion. In such cases calling for operation the condition of the suprarenal glands must be most carefully examined. This held also for many other operative measures. Cases of Addison's disease had been found with normal suprarenal glands after death, and on the other hand the glands had been found diseased with no symptoms of Addison's disease during life. The glands might be completely exhausted of adrenalin and yet no gross lesions be present. Again, though diseased, the remaining uninjured portions of the glands, together with the accessory chromaffin tissue, had been able to secrete a sufficient supply. In summing up Dr. Bruce said that there were present in the tissues numerous small bodies of a glandular structure. In many cases these were so small that they might almost be ignored, but these small bodies elaborated internal secretions which passed into the blood and were of such great importance that if their continued secretion were interrupted even for a short time death resulted. These bodies, like all other glandular and other tissues, were liable to become exhausted if any prolonged strain were put upon them, and their temporary exhaustion might lead to grave symptoms, and even sudden death.

Dr. BYROM BRAMWELL said that in 1875 he had published in THE LANCET a case of Addison's disease with only one capsule affected and with pigmentation. Such were very rare cases. Two French observers had said that the lesion was in the abdominal sympathetic system and not in the suprarenal glands at all. He thought that this might be true and would explain some of the difficult cases. He had likened the pigmentation to the eruption in fevers, and he had seen several cases without, or at least with very little, pigmentation. He had always laid great stress on asthenia as a diagnostic sign, and had recorded several cases with no tuberculous lesions. He was much dissatisfied with the adrenalin treatment of Addison's disease. The most successful cases were those in which there had been no tuberculosis of the adrenal glands. He thought that the sudden death in diphtheria and other diseases as being due to suprarenal exhaustion was merely a theory and not a proved fact. In cardiac failure in diphtheria there was often disease in the heart muscle or in the nerves going to the heart, and it rather strained the case to bring in the question of adrenalin insufficiency, and he also thought that cases of sudden death after operation for exophthalmic goitre were only very doubtfully due to suprarenal failing.

Professor F. M. CAIRD asked how could it be decided that a patient was suffering from adrenalin insufficiency, more especially if after death there was no disease present. In two cases he had employed repeated injections of adrenalin in normal saline fluid, and thought their lives were prolonged.

Dr. CLAUDE B. KER said that if heart failure in diphtheria could be prevented from 15 to 20 lives could be saved every year in his hospital. He had not been fortunate in the giving of adrenalin to his patients.

Dr. W. G. AITCHISON ROBERTSON thought that a continuous effect of adrenalin could be obtained by feeding patients with the glands as was formerly done in thyroid treatment.

Dr. D. BERRY HART thought that suprarenal graft might be employed.

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GLASGOW MEDICO-CHIRURGICAL SOCIETY.—A meeting of this society was held on Nov. 7th, Mr. A. Ernest Maylard, the President, being in the chair, when a lecture, with lantern demonstration, on the Prevention of Malaria, was delivered by Dr. Malcolm Watson, chief medical officer, Estates Hospitals Association, Klang, and member of the Malaria Advisory Board, Federated Malay States. Dr. Watson said that the miasmic and telluric theories of malaria had paralysed all efforts to eradicate the disease. It was Ross's discovery of the mosquito-carrier which pointed the way to the prevention of malaria. Successful anti-malarial work was first carried out early in 1901 in Klang and Port Swettenham in the Federated Malay States by the adoption, on his (Dr. Watson's) advice, of a thorough drainage scheme, which resulted in the practical abolition of malaria in these two towns and in a reduction in the number of deaths by about 400 per annum. In the same year Ross and Logan Taylor engaged in successful preventive work at Freetown, and in 1902 Ross inaugurated measures in Ismailia which brought about the disappearance of the disease there. In 1903 the publication of Dr. Watson's observations on malaria in rural districts led the Government to undertake the Kapar drainage scheme, embracing some 24,000 acres. There, by felling the jungle, draining by ordinary open drains the pools in which the anopheles umbrosus bred, and by cultivation, complete control was obtained over malaria on the low coastal land, which, on account of its stiff clay soil and high ground water, was supposed to be the stronghold of the disease. Among the hills, however, in spite of good houses on dry elevated sites, with pure water-supply and excellent sanitation, malaria of the most malignant kind persisted. Having found that this was due to the presence of the anopheles maculatus, which bred only in hill streams, Dr. Watson adopted the measure of carrying the streams underground in pipes for a certain distance, about half a mile, round dwelling places in hill land. This was done with complete success where the full distance was piped, and with marked improvement where a more restricted area only was drained. On the same lines the Government carried out an extensive subsoil drainage scheme in the federal capital, with the result that general malarial infection disappeared within the drained area. It was to the presence of this hill stream breeding mosquito that malaria was due in the hilly parts of Hong-Kong and in hilly districts in India, while to its absence from the hill streams of Italy, Sumatra, and the Philippines was to be attributed the freedom from malaria

which those regions enjoyed. In Japan the only anopheles mosquito found bred in rice swamps and carried only the two benign forms of malaria. During a recent visit to Panama Dr. Watson went to see most of the stations of the American Sanitary Department. While the Americans strongly advocated drainage, the engineering works constantly interfered with the drains. Mosquito-proof houses were used by the Americans and by some of the Spaniards, but the majority of the inhabitants were not protected. Quinine was practically not used as a prophylactic. The system of oiling, however, was perfect, the whole area for about half a mile round all dwellings being oiled once a week so thoroughly that every mosquito was killed. The two chief malaria-carrying mosquitoes, anopheles albimanus and anopheles argyrotarsis, were pool and not hill stream breeders. On a total area of 53 square miles thus treated in jungle under the worst possible conditions the Americans had built up and maintained a labour force of over 50,000 men, whose death-rate compared favourably with that of any corresponding population even in temperate zones. In British Guiana the inhabited portion of the country was a fringe along the coast and up the rivers, much of it having been reclaimed from the sea. Drainage, with the drain outlets protected by tide gates, and agriculture had brought about the disappearance of both anopheles albimanus and anopheles argyrotarsis, and had produced a fall in the incidence of malaria equal to that in Panama. Populations even lived in health on the edge of rice swamps, the mosquitoes being eliminated by a proper control of the irrigation. The freedom from malaria which distinguished Barbados among the West Indian islands had been attributed to the presence of the small minnows called "millions," which were supposed to eat the mosquito larvæ, but it was really due to the circumstance that the island was composed of a coral chalk so pervious to water that there were no surface pools, and consequently no mosquitoes could exist.

MANCHESTER MEDICAL SOCIETY.—A meeting of this society was held on Nov. 5th, Dr. C. C. Heywood being in the chair.—Dr. Donald E. Core read a paper on Some Clinical Types of Early Mitral Stenosis. Cases of latent mitral stenosis were described from the standpoint of prognosis and treatment; the possibility of auricular fibrillation and pulmonary infarction making their appearance without any subjective symptoms of hyposystole having been noticed was referred to. Groups of mitral stenosis in which the dominant symptoms were respectively those of wasting and those of functional nervous manifestations were also described. Emphasis was laid upon the importance of the double second sound in the diagnosis and prognosis of mitral stenosis.—Mr. J. Morley read a paper on Spinal Anæsthesia, which the lecturer considered should receive renewed attention in the light of Crile's views on shockless operations. Spinal anæsthesia afforded the only sure way of cutting off all traumatic afferent stimuli from the lower half of the body during operation, and so avoiding all tendency to nerve shock. In an experience of 66 cases operated upon under stovaine and glucose at the Ancoats Hospital during the past year it was found that a preliminary injection of morphine and scopolamine largely overcame the disadvantage that the patient retained consciousness and might be nervous. The technique of the method was described and the complications that might occur were discussed with their probable cause and prophylaxis. The method was advocated as suitable for routine use in all operations on the lower limbs, for hæmorrhoids and other perineal conditions, for operations on the bladder and urethra, and for inguinal and femoral hernia. For operations in the pelvis there was the drawback that the Trendelenburg position could not be used. The method was excellent for appendicectomy and exploration of the lower abdomen, but it was not advised for gastric operations necessitating the use of clamps. In acute peritonitis and acute intestinal obstruction it had the advantage over general anæsthesia in that there was less tendency to post-operative intestinal paralysis. In 19 operations on children the method was found satisfactory. Patients who had experienced operations under both general and spinal anæsthesia usually preferred the latter.

INCORPORATED SOCIETY OF MEDICAL OFFICERS OF HEALTH.—In his presidential address on Oct. 17th, Dr. A. K. Chalmers, the newly elected President, dealt with the Natural History of Pulmonary Tuberculosis in Scotland. He said that only 10 of its 33 counties showed rates below the mean of the country as a whole, and the densest shadows by no means covered the most thickly populated industrial counties. Although an interval of 69 per cent. separated the highest from the lowest rate there was a remarkable flattening in more than half of its counties. No fewer than 17 had rates between 10 and 13 per 10,000, while the lowest rate exceeded 5 and the highest was 18. Pulmonary tuberculosis in Scotch towns from the "seventies" onwards showed increasing freedom from its more fatal forms, and raised the question whether the tolerance which was being acquired was likely to prove more lasting in character. The experience of four Scottish counties had a bearing on this. Each had now a higher death-rate from all causes than in the 1860–2 period. But in three, Shetland, Orkney, and Caithness, the death-rate from phthisis had decreased by 17, 25, and 30 per cent. in the past 50 years, while the death-rate from other causes had increased by 3, 9, and 8 per cent. In Sutherland, while the phthisis rate had increased by 4 per cent., the death-rate from other causes had increased by 17 per cent. Round the Census period of 1871 the phthisis death-rate reached 2675 per million, and the county of Selkirk, which had been developing its manufactures at Galashiels in the midst of agricultural surroundings, doubled its death-rate from phthisis in 10 years, and from being third lowest in 1861, with a rate of 1534 per million, became second highest ten years later with a rate of 3380. The rise in the Selkirk rate was quite phenomenal; no increase elsewhere approached it; Lanarkshire alone, with a rate of 3888, exceeded it, but in 1860 it had been 3589.

MANCHESTER PATHOLOGICAL SOCIETY.—A meeting of this society was held on Nov. 12th, Dr. A. Brown, the President, being in the chair.—The President reported a case of Thrombosis of the Inferior Mesenteric Artery in a middle-aged man. The clinical picture was of severe colitis. The necropsy revealed extensive atheromatous change of the abdominal aorta. Thrombosis was complete in this vessel from the renal arteries to its bifurcation. The mucous membrane of the descending colon was black and gangrenous.—Professor R. B. Wild commented.—Dr. E. M. Brockbank demonstrated some slides of red blood cells illustrating what he termed "ballooning" and "visible hæmolysis," &c. From these he claimed to prove that the erythrocyte was a bladder whose outer membrane was of two layers. The hæmoglobin was held in solution inside the cell by means of chemical union with an unknown body. Inside each red cell also were the "platelets."—Professor A. E. Boycott gave a short address on the subject of Hypertrophy and Reserve Force. In explanation of the latter he adduced the theory of fractional activity of the elements of organs—e.g., all nerve and muscle fibres in a nerve or muscle not responding to every stimulus.—This was freely discussed by Professor Wild, Dr. W. E. Fothergill, Dr. A. E. Sellers, Dr. C. Powell White, and Dr. J. J. Graham-Brown.

GERMAN CONGRESS FOR INTERNAL MEDICINE.—The Thirty-first German Congress for Internal Medicine will take place in Wiesbaden from April 20th to 23rd, 1914, under the presidency of Professor Dr. von Romberg (Munich). The principal papers to be presented are: on Monday, April 20th Nature and Treatment of Sleeplessness, the reporters of which subject are Herren Gaupp (Tübingen), Goldschneider (Berlin) and Faust (Würzburg). On the third day, Wednesday, April 22nd, at 10 A.M., by the desire of the President, Herr Werner (Heidelberg) will present a comprehensive address upon the radiation treatment of new growths of the internal organs, and on the fourth day, Thursday, April 23rd, at 11 A.M., Herr Schottmüller (Hamburg) will deliver an address on the Treatment of Sepsis. Announcements of papers proposed to be read should be addressed to Herr Professor von Romberg, Richard Wagner Strasse 2, Munich. Addresses of which the essential details have already been published will not be accepted. Papers with summary of contents must be sent in by March 22nd, 1914. An exhibition of preparations, apparatus, and instruments, in so far as they are of interest for internal medicine, will be held. Communications with respect thereto should be addressed to the Secretary, Dr. Emil Pfeiffer, Parkstrasse, 13, Wiesbaden. In order to secure suitable accommodation for the visitors a committee will be formed to make the necessary arrangements.

# Reviews and Notices of Books.

*A History of University Reform from 1800 A.D. to the Present Time, with Suggestions towards a Complete Scheme for the University of Cambridge.*

By A. I. TILLYARD, M.A., St. John's College. Cambridge: W. Heffer and Sons, Limited. 1913. Price 10*s.* net.

IT is now very generally considered that although the Universities of Oxford and Cambridge can never become great clinical schools, for the clinical work and training of their medical undergraduates must be carried on in large populous centres, the preliminary literary and scientific training of the medical student will gradually fall, as it has done in the older universities, more and more into the hands of institutions of university rank. Within the last 25 years there have, of course, been very great growth and development in the medical schools of both Universities, accompanied by a gradual recognition by them of the importance of the early scientific training of the medical student. It is recognised, too, that a good classical, mathematical, philosophical, or literary training is of inestimable value to the medical man, and, when reinforced by what is spoken of as a scientific training, equips a man for the study of medicine as can no other curriculum. These studies can never take the place of clinical instruction, but they not only prepare a man to undertake his clinical studies with the best prospect of ultimate success, but assist him to continue to be a student during the rest of his professional career. A thoroughly trained man has acquired knowledge and methods which enable him to develop initiative, they give him the confidence that leads to prompt and effective action, and anything that will improve our university system must concern the profession of medicine in the persons of those engaged on its study and practice.

Our universities with their honourable history seem to have failed, from time to time, to keep pace with the demands and ideals of those most keenly interested in their welfare. Sometimes reforms, often the best of them, have come from within, but the conservatism naturally associated with such ancient and respectable institutions has, at other times, repressed the reforming spirits of the schools until they have been liberated from their bondage by external forces, and on numerous occasions interference from without has been necessary to break down the walls of tradition and prejudice.

In recent years a leaven has been working in both Oxford and Cambridge, a leaven so active that it has brought about a good deal of disturbance. But although some good work has been effected, the reformers, perhaps through want of sustained enthusiasm, from obstruction, or from want of knowledge, have as yet been able to advance but a few steps along the path of improvement and reconstruction. To meet this latter defect the author of this work, an *alumnus* of the University of Cambridge, has set himself to examine the various sources of information concerning both Oxford and Cambridge, and has given in concise and readable form the history of these two universities and of the many controversies that have arisen during the process of their evolution, producing a work so interesting and so complete that it may be commended to all who take an interest in these ancient foundations. He has examined with great thoroughness the earlier records of the universities and colleges. He indicates the method of growth of the colleges, which in the first instance were hostels in which were boarded the students attending the university; how as time went on the staff of the hostel came to assume tutorial functions, first in aiding the student to follow the professorial lectures, and then gradually assuming not the professorial function, but a tutorial function, displacing that of the professor, reader, or lecturer. With the development of the Natural Science Tripos and the growth of the medical school there has been a gradual reversion to earlier methods, and the college medical and science tutors have become directors of studies rather than tutors in the sense in which this term is understood in the classical and mathematical schools. Finally, in summing up, but keeping his facts and figures and his own opinions in water-tight compartments, the author suggests in a scheme of reform for the University of Cambridge the amalgamation of colleges into groups, by which economy of management, more effective instruction, keener competition, and a greater development of systematic and laboratory teaching would be obtained. The present system of prize fellowships is criticised very severely, and it is pointed out that if it is deemed expedient to help good men after they have finished their course of study this should be done systematically and according to clearly defined principles, and "two special cases are instanced in which career scholarships might be given with advantage to the community, these are the scholastic profession and medicine ..... Then again the medical course is long and expensive and it is of the highest importance to the State, especially in view of the recent legislation, that there should be a full supply of properly qualified doctors. These scholarships could be given by the University on the result of its own examinations. They are, however, a counsel of perfection as there are many more pressing claims."

It may be thought that a work of this kind must necessarily be dry reading, it contains so many facts and quotes so many figures, but on laying it down one feels that the author has, from start to finish, been able to maintain interest at a very high level, and whether, on certain matters of detail, we agree with him or not, we feel that he has given a full, comprehensive, and above all fair, account of the history of the universities and colleges and their relations, and that he has supplemented this with a suggested scheme of a practical character, though the needs for its application are not always as obvious as he believes.

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*Contributions to Practical Medicine.*

By Sir JAMES SAWYER, M.D. Lond., F.R.C.P. Lond., Consulting Physician to the Queen's Hospital, Birmingham. Fifth Edition. Birmingham: Cornish Bros. 1912. Pp. 410.

ALL the essays included in this book have previously been published in one or other of the medical journals, either in the form of clinical lectures or as separate articles, but for the purposes of this work they have been amplified and generally brought up to date. In the present edition important additions have been made, and the Lumleian lectures delivered at the Royal College of Physicians in 1908 are included.

Amongst the new essays is one entitled "Practical Summary of the Physiology, Pathology, Etiology, Varieties, and Treatment of Insomnia." This article appeared in "An Index of Treatment," by various writers, edited by Dr. Robert Hutchison,

and forms an addendum to the first two articles in the book on the causes and treatment of insomnia. A good summary is given on the principal points connected with insomnia; the remarks on hypnotics are practical in character, and may be read with advantage.

Another article is headed Practical Summary of the Etiology, Prevention, and Treatment of Habitual Constipation. This was first published as a clinical lecture in THE LANCET of Sept. 16th, 1911. Useful advice is given as to the general management of patients suffering from habitual constipation. Three main points are insisted on: (1) that the medicinal treatment of the constipation should not be left to the patients; (2) that a drug should not be prescribed until an attempt has been made to give relief without drugs; and (3) that drugs alone should not be relied upon, but other measures should be combined with them.

The Lumleian lectures on Points of Practice in Maladies of the Heart are characterised by essentially practical observations on diagnosis, methods of examination, and treatment of diseases of the heart. An account is given of the recent advances in the histology and physiology of the heart, but constant reference is made to the manner in which these advances can be made of service in actual clinical work. In discussing the division of maladies of the heart into two great classes—organic and functional—Sir James Sawyer shows how frequently these two groups are combined. He says that he finds it a good rule in practice to speak of the heart as *disordered* when there is no lesion, as *affected* when there is a lesion but no objective complication, and as *diseased* when there are both a lesion and some objective consequence of it. The differential diagnosis between organic and functional cardiac affections is often difficult, and in these lectures this point is discussed at length.

Sir James Sawyer's essays will be found especially valuable to those engaged in general practice, for much interesting information is given and numerous suggestions are made of considerable value from a clinical point of view.

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*The Development of the Human Body: A Manual of Human Embryology.*

By J. PLAYFAIR MCMURRICH, A.M., Ph.D., LL.D., Professor of Anatomy in the University of Michigan. Fourth edition, revised and enlarged, with 285 illustrations, several coloured. London: Henry Kimpton. 1913. Pp. 495. Price 12*s.* 6*d.* net.

THE author expresses the hope that this book furnishes an accurate statement of our present knowledge of the development of the human body, and this we believe to be the case. Development is the key to the significance of the structure, relations, and occasional anomalies of organs, and must form the foundation for a proper understanding of the facts of anatomy, human and comparative. To each chapter a short bibliography is appended.

The work is divided into two parts. Part I. deals with general development, and runs to 139 pages. It includes a short introduction on the cell and mitosis. Then follows an account of spermatozoa and spermatogenesis; the ovum, its maturation and fertilisation; segmentation and formation of the germ layers; the medullary groove, notochord, and mesodermic somites; the development of the external form of the human embryo; the yolk stalk, belly stalk, and "fœtal" membranes. This part is illustrated by 80 figures, many of which are taken from well-known authors, such as Kollmann, Sobotta, Wilson, Meves, Hatschek, von Beneden, Hertwig, Bonnet, Minot, and naturally the elegant figures of His are drawn upon to illustrate the outward form of the embryo. The sources are acknowledged. A number of the illustrations are original. Throughout the text all the illustrations are remarkably well printed, clear, and not overburdened with details.

Part II. deals with organogeny. The development of the following systems is considered in sequence: integumentary, connective and osseous, muscular, circulatory and lymphatic, digestive, respiratory, uro-genital, suprarenal, and nervous. There is a very full account of the development of the organs of special sense and a short chapter on post-natal development. In this part also many of the illustrations are taken from well-known memoirs or standard text-books by such authors as Szymonowicz, Testut, Sappey, Mall, van der Stricht—and for the reconstruction of the heart, Born—Keibel, Toldt, and many others.

Altogether this is a compact, handy, reliable, well-illustrated manual, and we commend it heartily as a course of study of the development of the human body.

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*Abhandlungen über Salvarsan.*

Gesammelt und mit einer Vorrede und Schlussbemerkungen herausgegeben von Professor PAUL EHRLICH, Wirkl. Geh. Rat, Direktor des Instituts für Experimentelle Therapie. Band III. Mit 2 Tafeln und 49 Figuren im Text. München: J. F. Lehmann. 1913. Pp. 584. Price, paper, 10 marks; bound, 12 marks.

THIS is a further instalment of the collection of articles and papers on salvarsan collected by Professor Ehrlich. The first group of papers in this volume deals with the question of the rise of temperature that may follow the injection of saline solution; then come papers on the employment of salvarsan in the army and navy, on its use to abort syphilis, on its effect on the nervous system, and on by-effects of the drug. Of great interest is the group of articles on the use of salvarsan in non-syphilitic diseases. Lastly, the results of neo-salvarsan are recorded in a series of papers, and Professor Ehrlich sums up the present state of the treatment. The book forms a storehouse of information for workers in this department of surgery.

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*Hygiene and Public Health.*

By LOUIS C. PARKES, M.D. Lond., D.P.H., and HENRY R. KENWOOD, M.B. Edin., F.R.S. Edin. Fifth edition. With illustrations. London: H. K. Lewis. 1913. Pp. 736. Price 12*s.* 6*d.* net.

A FIFTH edition of this standard text-book has been called for within two years of the fourth, and the authors have taken the opportunity to make revisions and additions which still further increase its value as a reference volume to practitioners in all branches of public health work and to students who require a comprehensive and trustworthy manual of the subject. The revisions are well up to date, including, for example, new administrative questions such as the duties now placed on medical officers of health by the Tuberculosis Regulations of the Local Government Board, the recent Tuberculosis Order of the Board of Agriculture in regard to the detection of tuberculosis in cattle, and the standards for sewage effluents proposed by the Royal Commission on Sewage Disposal in their eighth report. Important additions have been made to

the sections relating to communicable diseases and their prevention, including a useful summary of modern work on the phenomena of immunity, while those on food adulteration have been revised. The edition deserves, and is certain to receive, fully as much favour as its forerunners.

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*Die Chirurgie der Blutgefässe und des Herzens.*

Von Dr. ERNST JEGER. Mit 231 Abbildungen im Text, Berlin: August Hirschwald. 1913. Pp. 331. Price 9 marks.

ONE of the most striking advances in surgery during the last few years has been in the surgery of the vascular system, and several works have already appeared devoted to the consideration of the surgery of the heart and of the blood-vessels.

In this book the author deals with both branches of the subject, which is fully considered, both from the experimental side and from the point of view of its application to practical medicine. Although the practice of suturing vessels is still young, we have advanced sufficiently far to learn some of the essentials of operations on vessels, and rapid progress is still being made. The book contains an account of most of the experimental work that has been done, especially in the transplantation of viscera. The chapter on experimental heart surgery is especially interesting. The dedication to Dr. Alexis Carrel recognises his work as a pioneer in this branch of surgery.

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*Das Wechselstrombad.*

By Professor A. STRUBELL. Dresden: Theodor Steinkopf. 1913. Pp. 210. Price 7 marks; bound, 8 marks.

THIS monograph on the Hydro-electric Bath proceeds from the Institute of Physical Diagnosis and Therapy of Diseases of the Heart at Dresden. It is a good example of the thoroughness and scientific accuracy of the German school of electrotherapeutics. There are 400 cases, carefully tabulated with observations of the pulse frequency, the blood pressure, and in many cases the electrocardiogram, taken at intervals of five minutes, before, during, and after the bath. The hydro-electric bath with sinusoidal current has been found useful in a variety of diseases, in neurasthenia, goitre, and arteriosclerosis, as well as in myocarditis and valvular disease of the heart. In addition to the account of the author's own work the book contains a long chapter on the history of the hydro-electric bath and sections on the theory and indications for the treatment, as well as a practical chapter on the installation of apparatus. It is illustrated with numerous electrocardiograms, and will be for a long time an authoritative work on this subject.

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## LIBRARY TABLE.

*Minds in Distress: a Psychological Study of the Masculine and Feminine Mind in Health and in Disorder.* By A. E. BRIDGER, B.A., B.Sc. Paris, M.D. Lond., F.R.S. Edin. London: Methuen and Co., Limited. 1913. Pp. 181. Price 2*s.* 6*d.* net.—This is a somewhat difficult book to classify. Though written by a medical man and treating of diseased conditions which, however obscure in their nature, are more or less clearly recognised as nosological entities, the volume makes a clean sweep of the current conceptions and the customary phraseology of medicine, and on the *tabula rasa* so prepared sets out a new view of functional nervous disorders. The attempt must strike the reader as rather audacious, and in spite of the admiration which will certainly be felt for the author's courage and for the energy and enthusiasm which he has brought to this difficult task, it can hardly be said that the result is altogether happy. Dr. Bridger prefaces his thesis by laying down two principles which he describes as "of universal acceptance, free of speculative theory, and reducible to the simplest terms." One of these principles is that mental comfort depends on a "state of balance" between two main factors in the mind, one factor being what he terms common sense, meaning thereby the accumulated experiences of the individual blended with the accepted opinions of his *milieu*, while the other factor is made up of the new impressions from all sources which are presented to the common sense as to a standard. A failure in the balancing of these two factors will give rise to mental distress, varying in its manifestations according to the type of the sufferer's mental organisation. And here we come to the author's second main postulate—viz., the existence of two main types of mind: the masculine, characterised by the predominance of the reasoning, and the feminine, characterised by the predominance of the instinctive faculties. Loss of balance in the masculine type of mind constitutes, in the author's view, the essence of neurasthenia, which he accepts as synonymous with "hypochondria, psychasthenia, nervous breakdown, or depression," while on the other hand hysteria in all its manifestations translates loss of balance in the feminine type of mind. If Nature would accommodate herself to schematic divisions this extremely simple view of normal and morbid psychology would perhaps serve some practical end in classification, and its not oversubtle speculation might then be provisionally admitted; but in actual clinical experience it is to be feared that the facts are more complex and more obscure than they appear to Dr. Bridger's philosophy. Interesting, therefore, and suggestive as many of his remarks undoubtedly are, his views as a whole are hardly convincing.

*Resuscitation from Electric Shock, Traumatic Shock, Drowning, Asphyxiation from any Cause.* By CHARLES A. LAUFFER, A.M., M.D. New York: John Wiley and Sons. 1913. Pp. 47. Price 2*s.* net.—This is a small volume relating to the use of the prone pressure (Schaefer) method of artificial respiration for the relief of asphyxiation from any cause, and is intended for the use of those engaged in dangerous occupations as well as for the public as a whole. As the author rightly points out, we live in the midst of dangers undreamt of by our forefathers, and every new development for the good of humanity brings its own risks and dangers with it. Consequently it is more than ever necessary that every active member of the community should have some idea as to the proper way to restore those rendered unconscious or apparently dead from accident. The method is here clearly described, so that it can be easily understood by anyone of average intelligence, and there is no doubt that a more general dissemination of this knowledge would be for the good of the public.

*Dictionary of German and English and English and German.* By MAX BELLOWS. Proofs revised by CLARENCE SHERWOOD, Ph.D. Berlin, and WILHELM JOHANN EGGERS, M.A. Lond. London: Longmans, Green, and Co.; Brunswick and Berlin: George Westermann; Vienna: Rudolf Lechner und Sohn;

New York and Chicago: Henry Holt and Co. 1912. Pp. 806. Price, cloth, 6s. net.—This work has been arranged on similar lines to the late Mr. John Bellows's "French and English Pocket Dictionary." His son, Mr. Max Bellows, the compiler of the present dictionary, hopes that a pocket edition may one day be published. The work is prefaced by general rules of grammar and tables of verbs, and tabular comparisons between the metric and British systems of weights and measures. These we have tested in many instances, and have found no errors (excluding, of course, the alterations made in the standards by the English Board of Trade and the United States Board of Standards). The author says that he has endeavoured to bring the subject matter thoroughly up to date. It certainly contains words for "Women's Suffrage," "Manhood Suffrage," and "Home Rule." The dictionary contains a foot-note at the bottom of each page to state that "words common to both languages are given in the German division only." We do not see the word "Conservative" in the English portion, although it is to be found under "Konservativ" in the German portion. A German scholar would of course know where to look for it, but perhaps not another. We do not see the German equivalent for "Cinématographe," which, according to Langenscheidt's new Taschen-Wörterbuch, appears to be "Kinematograph," but picture palaces are advertised in German newspapers as kino-theaters. We observe that "M.R.C.S." and "F.R.C.S." are both translated as "Mitglied des königlichen Instituts für Chirurgie," but we do not see "L.R.C.P." or "L.S.A." In another edition the word "Referat," meaning "report" or "discourse," which is now so frequently used, might be included in both sections. But too much cannot be expected of a dictionary of this compass, which contains a large amount of information on many terms. Such, for instance, is voyal or Kabelar, a nautical term, not found in some other dictionaries either small or large. The work has evidently been prepared with care, and is well printed in clear and neat type. It is a most useful addition to the library of the English or German scholar.

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## MISCELLANEOUS VOLUMES.

IN fiction and poetry a few books call for mention. The "pathological novel" is still in evidence. One of the latest of such publications is *Tantalus* (London: T. Werner Laurie. Pp. 260. Price 6s.), by the author of "The Adventures of John Johns." It is not a pleasant book, being a more or less accurate picture of the development of the neurasthenic condition in an exceedingly objectionable egoist. Medical men do not need such pictures in their fiction—they come across them only too frequently in their professional reading and in actual life—while they cannot be pleasant or profitable to the ordinary lay reader.—According to "A. de O.," one Richard Carstairs was a noted Queen Anne-street physician—or rather general practitioner and hospital surgeon and obstetrician, for he appears to have undertaken all sorts of cases—who, being an excellent *raconteur*, was dared by some friends at a dinner party to write a book of stories, his capacity for writing stories as well as he could tell them being challenged. He began to do so, but died before he had more than put together the notes thereof, which he entrusted to "A. de O.," who thereupon put them together and published them under the title of the *Indiscretions of Dr. Carstairs* (London: William Heinemann. 1913. Pp. 318. Price 6s.). The stories are for the most part pathological, either of mind or body, or both. We quite fail to see the usefulness for public reading of any such passage as the following: "Directly I had cut through the muscles and opened the peritoneal cavity it was only too clear that my worst fears were realised. The liver was studded with small grey nodules, the pancreas was hard and irregular in outline, nodules of hard, dense tissue were abundant throughout the intestine." The proper place for such a passage is a Students' Aid to Pathology, not quasi-fiction—for we doubt if all the stories are entirely imaginary. The Indiscretions of Dr. Carstairs's Patients would seem to be a more appropriate title for the book. Perhaps the best of the stories, and the one to which least, if any, objection can be taken, is Adrift; but even that is marred by the introduction of prominent personages—notably Mr. Gladstone. What is narrated here, if it is not a fact is an outrage, and if it is a fact, is indeed an indiscretion of Dr. Carstairs—or "A. de O."—Dr. "OSTON," whose stories of "Queer Patients" we noticed in our issue of Oct. 7th, 1911, has now produced in *Born in Blinkers* (London: Murray and Evenden. 1913. Pp. 351) a plain, honest story of plain, honest people, chiefly dealing with Edinburgh University and the fortunes of three students thereof. The ending is conventional and happy.—An intelligent story for those who love an old-time flavour is *Idonia: a Romance of Old London*, by ARTHUR F. WALLIS (London: Sampson Low, Marston, and Co., Limited. 1913. Pp. 317. Price 6s.). It aims at the "spaciousness" of the Elizabethan age: we have high adventure by land and sea, a venturesome, none too tactful youth, and a maid who retains her charm in an environment of crime. The story ends in the peace of a reunited family. The manner in which the author consistently maintains throughout the Elizabethan diction—for the story is told in the first person—shows genuine literary skill.

The present era is hardly tolerant of the sentimental, but as an exemplar of the ideal of romantic love, Goethe's *Hermann and Dorothea* remains conspicuous, in Germany, at any rate. Captain VIVIAN BRANDON evidently was engaged in a labour of love in his translation thereof (London: T. Werner Laurie, Limited. Pp. 95. Price 3s. 6*d*. net.) into dodecasyllabics, the form of verse considered by him the nearest convenient English equivalent of the original German hexameters. A continued poem in either hexameters or dodecasyllabics becomes generally monotonous in the uniformity of its rhythm, though in Latin (and in English as Swinburne handled it) a skilful use of the cæsura greatly mitigates this defect. Captain Brandon's versification is flowing and smooth, largely due to his grasp of English, and he uses a preponderance of one-syllabled words. The writing of it lightened the tedium of his recent "enforced leisure" in the German fortress of Wesel. The reading of it may also lighten the enforced leisure of many a bedridden patient.

The value of golf as a hygienic pastime, especially to persons of middle age, combining as it does the advantages of an outdoor life, much walking, and not too violent exercise involving the body as a whole, justifies a reference here to two recent books on the subject. EDWARD RAY, open champion 1912, in *Inland Golf* (London: T. Werner Laurie, Limited. 1913. Pp. 234. Price 5s. net.) discusses the game from the

viewpoint of the player who has learned and played his golf on inland links. The extraordinary development of the golf cult during the past 20 years, a development which shows no signs of abating, is responsible for the evolution of the distinctive methods of inland as opposed to seaside play. The rise of such inland courses as Walton Heath, Mid-Surrey, and Sunningdale, with their hazards, fairway, and distances elaborately planned to furnish the most searching test of play, with their perfect greens laid out to imitate every kind of natural variation to be found on the best seaside courses, has created a species of game which demands possibly greater skill than ever before. Seaside and inland golf are widely differentiated games, and others besides Ray claim that the inland is the more difficult. The writer, after an introductory chapter on the Rise of Inland Golf, discourses in an easy and pleasant style on the choice and use of the various clubs and on the ways in which different shots demand, for their execution on inland turf, methods which vary from those required on seaside links. Chapters on Play in Wind, the Negotiation of Inland Hazards, the Secret of Long Driving, Imitation, Straight Tips, and the Versatile Niblick, include many points of keen observation, and many original suggestions from the play and experience of the author, who does not hesitate to poke a little quiet fun at his own "unorthodox" peculiarities. There is a sufficiency of excellent photographs. A short index would be useful.—*Golf Practice for Players of Limited Leisure*, by HENRY HUGHES (London: Thomas Murby and Co. 1913. Price 2*s.* 6*d.* net), is a short guide which beginners will find of use. The acquisition of an effective style is taught by detailed instruction, beginning with the "stance" and the "grip," and working through the different clubs from driver to putter. The method of the author is careful and painstaking; he goes into minute detail, and, failing a garden, advocates home practice even on a boarded floor. A series of large full-page photographic illustrations helps out the printed directions.

## JOURNALS AND MAGAZINES.

*Quarterly Journal of Experimental Physiology.* Editors: E. A. SCHÄFER, W. D. HALLIBURTON, C. S. SHERRINGTON, E. H. STARLING, and A. D. WALLER. Vol. VII., No. 1. London: Charles Griffin and Co., Limited. 1913. Pp. 1–101. Price 7*s.* 6*d.*—The General Condition of the Spinal Vaso-Motor Paths in Spinal Shock, by F. H. Pike. This communication is one of three on the Physiology of the Central Nervous System—the two previous papers were published in 1909 and 1912 in the *American Journal of Physiology*. This paper is a highly interesting one, but the space at our disposal is not sufficient for us to give a detailed account of the experimental results, while the discussion thereon alone occupies six pages.—An Investigation of Nerve Regeneration (eight figures in the text), by Henry O. Feiss. After a short historical introduction and the setting forth of the autogenic and outgrowth theories, the author describes his method of multiple ligatures applied to the peroneal nerve in adult cats—a nerve both long and easily accessible. The staining methods used were those of Weigert-Pal and Cajal. The author infers that regeneration proceeds centrifugally from a central source, but the neurilemmal sheaths must be in a proper condition, both mechanically and nutritionally, to receive the newly regenerating fibres. The manifestations of this central regeneration are often discontinuous, as the scars form regions of obstruction to the outgrowing nerve fibres. The sheath cells do not have inherent properties of neuroblasts. Fibres which have degenerated may show regeneration in the anatomical sense, with good myelination, even if they are prevented from making connexion with the peripheral end organs.—The Chemistry of the Mammary Gland, by J. Argyll Campbell. Up to the present practically nothing is known about the quantitative composition of this gland as regards water, protein, fat, and sugar The author finds that gland tissue from lactating bitches and cats shows considerable differences between different parts of the same gland, between glands of the same animal, and between glands of different animals of the same species. Lactose is found only when the gland contains milk, and is not found in the gland of a pregnant animal. It is concluded that as lactose is not a constituent of the parenchyma cells, it must be formed from some other substance in the process of secretion into the alveoli. The fat obtained from the gland cannot be taken as an indication of the amount of milk constituents it contains, as fat is found both in the parenchyma cells and in the adipose tissue between the alveoli.—The Vascularity of the Liver, XI., the Motor Reaction in the Portal Radicles of the Liver, by Russell Burton-Opitz. Relying on the action of adrenalin while perfusing the liver, the author concludes that the radicles of the portal system of the liver possess motor activity; the hepatic plexus innervates this motor system. The portal mechanism includes the distributing tubules and the central collecting channels, and it is distinct from the mechanism of the terminals of the hepatic artery.—The Antagonism between Adrenine and Chloroform, Chloral on the Heart, Induction of Rhythmic Contractions in the Quiescent Heart by Adrenine, by James A. Gunn. An isolated heart of a cat or rabbit was used and perfused with Locke's fluid (without glucose). Adrenine can antagonise a heat enfeebled with chloroform, and has a more complete antagonism to chloral, as it can revive rhythmic contractions in a heart arrested in diastole by chloral. These contractions are regarded as independent of intrinsic motor ganglia.—On Age and Metabolism, and on the Significance of the Excretion of Creatine, by R. A. Krause. Creatine occurs in the urine of children; in boys creatinuria ceases about the fifth to sixth year; it persists longer in girls. The power to assimilate creatine is much less in children than in adults; even 0·3 gramme is excreted.

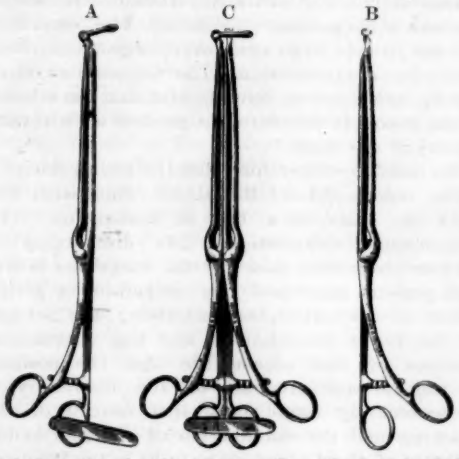
*The Child* for November opens with a very readable article by Sir John Kirk, director of the Ragged School Union, and well known for his active interest in the welfare of the poorer children of our metropolis. He contrasts the insanitary conditions of 50 years ago with the improved conditions of to-day, and asserts that after making every allowance it cannot be denied that child life in England to-day compares most favourably in all respects with the conditions which obtained in the early "sixties" of the last century. It is a felicitous thought of the author that the child exemplifies the truth associated by Tennyson with the flower in the crannied wall. Dr. Harry Campbell writes on Diet and Child Welfare, and Mr. J. R. R. Trist discusses the Taking of Medicine by Children, pointing out that mothers who keep a nursery medicine cupboard frequently do not seem

to know that a drug which is capable of doing good is also capable of doing harm. He calls attention to the danger of over-confidence in the mother's skill of treatment, with the consequent danger of "curing" the symptom regardless of its cause. He thinks that two drugs only need be found in the nursery medicine cupboard—viz., castor oil and camphorated oil. Other articles of interest are the Training of Nurses as a Profession for Gentlewomen, by Mr. Bransby Yule; and Child Welfare Work in Westminster, by Dr. F. J. Allan, medical officer of health.

# New Inventions.

## GASTRO-ENTEROSTOMY CLAMPS.

THE gastro-enterostomy clamps illustrated below can be applied separately and then easily combined (C) so as to hold the stomach and jejunum in suitable apposition without the help of an assistant. The clamps can be disconnected without sliding one on the other, and consequently without exerting any strain on the stitches uniting the jejunum to the stomach. As shown in the figures, the ratchet of each clamp is visible in the position in which it is applied, and so the degree of compression exerted is easily recognisable. As a rule, sufficient compression is obtained by clamping to the second notch, sometimes to the third. The clamp for the stomach (A) is of a slightly stronger




build than that for the jejunum (B). The length of the clamping surface of the blades is 5 inches. The clamps were made for me five years ago by Messrs. Mayer and Meltzer, of Great Portland-street, London, W., and after repeatedly using them during that period I find they possess all the requirements I need in gastro-enterostomy clamps.

BILTON POLLARD, M.B., B.S. Lond., F.R.C.S. Eng.
Harley-street, W.

PRESENTATION TO A MEDICAL MAN.—Mr. Stuart H. Kingston, M.B., M.R.C.S. Eng., was recently entertained at dinner by former fellow residents on resigning the post of senior medical officer at Bristol Royal Infirmary, and a presentation was made to him.

LONDON (ROYAL FREE HOSPITAL) SCHOOL OF MEDICINE FOR WOMEN.—The annual dinner of the hospital and school will be held at the Trocadéro Restaurant, Piccadilly-circus, on Wednesday, Dec. 10th, at 6.45 for 7.15 P.M. Dr. J. Walter Carr will take the chair. Applications for dinner tickets (price 7*s.* 6*d.* each) should be sent to the honorary secretaries, Dr. Winifred Cullis, 8, Hunter-street, Brunswick-square, W.C., and Dr. Frederick Langmead, 47, Queen Anne-street, W., not later than Nov. 29th.

# THE LONDON COUNTY COUNCIL AND MEDICAL AFFAIRS.

### *Dispensary Treatment of Tuberculosis.*

IN connexion with the preparation of a comprehensive scheme for the treatment of tuberculosis in London[1] the Public Health Committee on Nov. 18th invited the London County Council to decide the general principles upon which it will approve the local dispensaries which are to be administered by the borough councils. It was proposed that borough councils should make arrangements to pay for patients residing in the district under their jurisdiction attending dispensaries attached to hospitals in any part of London, and the following were the conditions which the Council should require to be observed in any local scheme for the provision of dispensary treatment:—

(i.) The Council must be satisfied that the premises are suitable.

(ii.) The scheme must include provision, either in the dispensary or at a hospital working in connexion with the dispensary, for the diagnosis of ordinary straightforward cases, and of incipient, anomalous, and difficult cases specially referred on the ground of difficulty of diagnosis.

(iii.) The physician in charge of the dispensary (or "tuberculosis officer") must be a man of experience, not only in dealing with tuberculous affections, but also in general medicine.

(iv.) Proper records and statistics in connexion with the work of the dispensary shall be provided of the nature and in the form required by the Council and approved by the Local Government Board.

(v.) The physician in charge of the dispensary shall supply to the medical officer of health of the borough from which the patients are drawn such information as the medical officer of health may reasonably require, and the county medical officer of health shall be entitled to receive this information from the borough medical officer. The physician in charge of the dispensary shall also furnish the requisite information to any medical practitioner carrying out domiciliary treatment, or, in a case which is referred to a sanatorium, to the medical officer of the institution.

(vi.) The scheme shall include provision for home visitation of patients, either by the dispensary physician or by the medical officer of health of the borough or his staff, and for the examination by the dispensary physician of such cases as the medical officer of health or a medical practitioner may require, either at the dispensary or in the homes of suspects and contacts.

(vii.) The scheme shall be conducted with reasonable economy and the expenditure shall be annually submitted to the Council for its approval.

(viii.) The scheme shall provide for distinguishing clearly between the cost of treating insured and uninsured persons, having regard to the opinion expressed by the Council that insured persons should not be paid for out of the rates.

The report was approved.

### *Control of Lying-in Homes.*

The Midwives Act Committee reported with reference to the decision of the Council to promote legislation for the control of lying-in homes and institutions[2] that as the Council had decided to proceed by means of registration in the case of nursing homes and massage establishments[3] the committee thought it best to withdraw its proposal to license lying-in homes and to substitute the policy of registration. The Council decided to seek Parliamentary powers on the lines recommended by the committee.

### *Basis of Medical Inspection and Treatment Grants.*

It was reported to the Education Committee of the Council on Nov. 12th that the Board of Education has decided to make grants for medical inspection as well as treatment, and when satisfied that the provision was adequate and the working efficient, to pay a grant at the rate of one-half of the expenditure, and otherwise either to pay at a lower rate or withhold the grant. The effect of the change is that whereas the grant last year represented only 28 per cent. of the total expenditure, the Board is now prepared to pay at the rate of 50 per cent. The points which the Board will take into consideration in deciding the quality of the school medical work are the inspection of the groups prescribed by the code, the following up and treatment of cases of defect found in the course of medical inspection, the coördination of the work with the general public health service, and the organisation of school medical work as an integral part of the education system.

[1] THE LANCET, Nov. 15th, p. 1413.
[2] THE LANCET, Oct. 25th, p. 1206.
[3] THE LANCET, Nov. 15th, p. 1409.

# THE LANCET.

*LONDON: SATURDAY, NOVEMBER 22, 1913.*


## The University of London: the Position of the Government.

A LETTER addressed by Mr. J. A. PEASE, the President of the Board of Education, to Dr. W. P. HERRINGHAM, Vice-Chancellor of the University of London, was sent to the press at the end of last week by Mr. PEASE, and has received such wide publicity that there is no need for us to reproduce it. All interested will have read it. The letter states very frankly the desire that the position of the Government in regard to the proposed reconstitution of the University of London should be generally realised, so that future discussion of the subject shall be as far as possible free from misunderstanding, and we wish it were possible to believe that this desire will be achieved. To a great extent Mr. PEASE'S letter was a repetition of his speech made some fortnight ago at the distribution of prizes to the successful students of the City and Guilds Institute at the Mansion House, so that for some days past we all of us have been aware of the views entertained by the Government upon the Report of the recent Royal Commission upon the University, but we have not observed that knowledge of these views has produced a tendency among those who had previously held diverging opinions to alter their attitude in any direction towards a common reconciliation.

The Royal Commission over which Lord HALDANE presided, it will be remembered, published a unanimous report, an abstract of which, with special reference to the Medical Faculty, appeared serially in our columns. The substance of this report made it clear that there were going to be great differences in the public estimate of the merits of many of the recommendations, even though on all hands the clearness and conciseness of the document was admitted, as well as the receptive attitude of the Commissioners and the skill with which they had made summaries of involved situations. The differences indeed were inevitable, for the recommendations brushed aside objections to reform in certain directions with a completeness that could not fail to be painful to many a loyal upholder of the University of London, as far as previous conceptions of the responsibilities and duties of that University was concerned. But the Commissioners achieved one thing in the course of dealing with recognised ills of long existence which it behoves medical men to remember—they made it quite clear that our profession will be wrong if we consider that the problem of the reform of the University of London is only concerned with improving the scheme of medical education in London, or with perfecting the Medical Faculty. The position of the London medical student who, despite his admirable training and his unrivalled clinical opportunities, does not possess the same facilities for obtaining a degree in medicine at his local university that are possessed by other medical students, has, of course, always been a main subject of interest for our readers and ourselves. It will continue to be such a main subject of interest, but in the discussions which are sure to ensue, and ensue shortly, it will be necessary for us to recollect that an enormous sum of money will have to be found by the State for the needs of the University as a whole, and that that sum of money will not be allocated in particular to the scientific and medical faculties. The Departmental Committee, which has been appointed by the Board of Education to consult the bodies and persons concerned in the reform of the University, will recommend the special arrangements and provisions which may be immediately adopted, to quote the words of Mr. PEASE'S letter, "for the purpose of giving effect to the scheme of the report of the Royal Commission and as the basis of the necessary legislation. The Committee will not attempt to go again over the ground covered by the Royal Commission. The Government, after careful consideration, have decided that the scheme of the Report is calculated to produce a University worthy of the name."

We now know, therefore, that the main principles of the report of Lord HALDANE'S Commission will form the basis of a Bill in Parliament. The Departmental Committee is now discharging its duty in discovering how far the numerous bodies and persons concerned can coöperate in giving effect to the principles underlying the scheme of the Royal Commission: and the outstanding features of that scheme are that the position of the internal students of the University is to be securely established; that control of the teaching and the examination of students in the colleges of the University is to be in the hands of the teachers; that the educational and financial control of the constituent colleges is to be vested in the University; that the government and financial administration of the University is to be entrusted to a small Senate; that as far as possible the work is to be concentrated in a central University quarter; and, lastly, that the scheme of reconstruction is to provide effectively for continuance of access to University examinations by external students—that is, by those who are not attached to any college or school of the University. Every one of these principles, which are to be recognised in future action, may be criticised by someone. The size of the Senate, the privileges and deprivations of the constituent colleges, the particular site, and the facilities offered to external students are all points upon which acute variations of view may be expected; but Mr. PEASE indicates in weighty words that

the scheme of the report of the Royal Commissioners ought not to be rejected by the public "because in this point or in that it may fall short of their ideals or is even contrary to what they think best." He asks for sacrifice on individual points, because this is necessary for the carrying out of the scheme as a whole, and reminds us that it is the only one in the field, and that if it should fail of accomplishment all chance of reform and progressive development may be lost for many years. The gravity of the situation is best realised by adding to his words the comment that the sacrifice in some instances will mean the surrender of things believed by many to be the things that matter most.

As far as the great aims of education have to be reckoned with there is one part of the scheme of the Royal Commissioners which seems to be at first sight of less importance than the others, and that is the recommendation that a central site for the reconstituted University should be chosen. The balance of the claims of the external and internal students, the demands for adequate professorial instruction, the bringing into proper line of the work of research with ordinary academic teaching, the simplification of the medical curriculum—surely these are all great questions compared with the question of the site where the work shall go on; and yet it is a curious circumstance that there may be practical reasons for settling the question of the site of the University first. To have this one concrete source of dispute cleared away may assist in the evolution of a fair and symmetrical method of reconstructing the University. No one scheme that exactly suits the external students can exactly suit the internal students, but if the central site is chosen first its selection may prove a powerful factor in the development of concessions in this direction or that, which are hard to exact at the moment when there is no assured and material condition by which their amount can be estimated. The merits of the various available sites are now the subject of close scrutiny, and it is certain that the convenience of coming to a decision on the matter at an early stage in the work of reconstruction has made itself apparent to others than opportunists. Sacrifices are expected from all concerned, and it is fair to suppose that those who get what they want in one way will be ready to yield in other ways.

## Florence Nightingale.[1]

WHEN Miss NIGHTINGALE died in 1910, at the age of 90 years, her work was so long overpast that the necessary perspective for reviewing it was as easily attained as if she had already been dead for many years. Nay, its remoteness was sufficient for the accumulation of those mists of tradition which veil the past and obscure the sharpness of its outlines. From the earliest Crimean days a strong trace of religious idealism attached to the hero-worship which the British army and the British public so freely accorded to her. Miss NIGHTINGALE'S aversion from publicity and ostentation, and the secluded semi-invalid life she led, even when she was actually exceedingly busy from her sofa in constructive reform, contributed towards the popular conception of her as one hardly lower than the angels. The real FLORENCE NIGHTINGALE was a much more human person; not less remarkable or less competent than report painted her, but certainly more of a diplomatist and woman of the world.

It is this FLORENCE NIGHTINGALE that Sir E. T. COOK reveals in a biography which ranks in the very highest class of that difficult literary art. His critical summary of her character begins with the statement that she was "by no means a Plaster Saint," and in this reversal of the verdict of mid-Victorian England all who read Sir E. T. COOK'S volumes must agree. She was a woman of imperious will, not good either at forgetting or forgiving; nor could she suffer fools, gladly or otherwise. Industrious and business-like herself in the extreme, she despised men or women who were not. She had no use, as Sir E. T. COOK says, for "angels without hands," and was essentially a "man of facts" and a "man of action." Indeed, her character was in some respects more masculine than feminine. (She described once in a letter "the difference between myself and other men," a pleasantry which hid just a grain of fact.) She did not relish any independence in opponents; she displayed at times distinct hardness; she was not very tolerant; she had a talent for political intrigue, which she exercised freely to further her projects. These traits may not be a necessary part of greatness, yet they are often found in great men. To them Miss NIGHTINGALE united others which great men often lack, great women rarely. Pity, sympathy, compassion, devotion to the sick, were felt even more deeply than they were exhibited, for self-revelation was wholly alien to her nature. For sheer intellect few women of the last century can compare with her; in addition, she had also great charm, and a wit which was frequently pungent. "Masterful in action," says Sir E. T. COOK, "she was humble, even to the verge of morbid abasement, in thought." Intensely religious, she was in some ways impatient of creeds and formulas; and hygiene for the body she placed antecedent to care of the soul. Her genius lay most of all in command and administration; in the selection and training of subordinates; and in military virtues of discipline for herself and others. Thus is explained her fervent affection for the soldiers, alike in times of war and times of peace.

Miss NIGHTINGALE in short was one of those exceptional beings whom the vast majority must admire and reverence but cannot hope to equal.

[1] The Life of Florence Nightingale. By Sir E. T. Cook. London: Macmillan and Co. Two vols. Pp. 1017. Price 30s. net.

The medical profession can especially appreciate her achievements, for she forged its trustiest weapon, the modern nurse. Jealous as she was for the honour of her nurses and of nursing, and bitterly as she differed from some of the medical authorities of the day, those who study her life story carefully will see in her many of the attributes of the ideal surgeon. The patience and the serene indifference to criticism of LISTER were not hers; but in other respects she exhibited qualities which were present also in the founder of modern surgery, and it is conceivable that had she been a man she would have become a surgeon. That she actually on one occasion attacked Listerian doctrines is no proof that she would have failed to grasp those illuminating conceptions had she been a trained scientific worker in the same field. She had the surgical temperament strongly developed, as the interested may deduce from the evidence afforded in this book. Hence the story of FLORENCE NIGHTINGALE'S life has an interest for the medical profession beyond that of her actual work, closely as this, too, touches on medical science. Intrepid, self-sacrificing, clear-headed, deft-handed, tender, intellectual, resolute, retiring, and a marvellous organiser, she surpassed both in achievement and in personality all other Englishwomen in an age notable for its noble women.

# Annotations.

"Ne quid nimis."

## MOSQUITOES IN AND ABOUT EPPING FOREST.

IN this country the bite of the mosquito or gnat has not in ordinary circumstances to be dreaded as a possible carrier of serious infections like malaria, and is generally considered as one of the inevitable minor annoyances of life, calling merely for a very moderate exercise of philosophy and patience. Such annoyances, however, are by no means to be disregarded from the point of view of public health, if it is practicable to remove them, and it must be admitted that the suppression of the swarms of biting insects which are common on the outskirts of London and other large towns would be worth some effort. Some individuals have special susceptibility to gnat bites, and show a strong reaction to them; the bite is sometimes, though rarely, the starting point of septic infection; while town dwellers whose only opportunity of using their gardens or recreation grounds is the evening often find their outdoor rest or recreation seriously curtailed. From this point of view we welcome a report of a conference on the "Mosquito Nuisance," convened in September by the urban district council of Chingford, and attended by representatives of the chief local authorities in the neighbourhood of Epping Forest. The medical officer of health of the Chingford district, Mr. T. S. Brook, who had given close attention to the subject, urged with much reason that the prevalence of these biting insects should be taken seriously as a matter of local sanitary administration, and his views appear to have received general acceptance. Mr. Brook was able to present an interesting report on the natural history of the common mosquitoes and gnats of the neighbourhood and their suppression, made by Mr. E. H. Ross, a research officer of the McFadden Research Fund. Mr. Ross found, as might, perhaps, have been expected, that the culices here in question did not breed to any notable extent on any of the larger expanses of water in Epping Forest, or even in the larger cattle pounds. And while they were frequently present in puddles and pools of stagnant water in the open spaces of the Forest, their abundance was much greater in the enclosed grounds of the neighbourhood, particularly in the water-butts of private gardens. It is argued, in fact, that the local "plague" which received so much attention last summer could have been very effectually reduced by a coöperative action of the inhabitants, which it should not be difficult for an intelligent local authority to secure. Much could be done by systematic visits to houses and the circulation of information. As a counsel of perfection all water-butts should be emptied once a week, but failing this a weekly oiling is as efficacious. There is no reason to apprehend damage to plants from water thus treated. Small vessels which have been left lying about and collect rain water are also great offenders the remedy for which is simple. The attempt of the local authorities to secure the assistance of householders in such respects, combined with arrangements for removing obstructions from stagnant brooks, for filling in small unnecessary pools and like matters, will be watched with interest when it is made, as we hope it will be, in the coming year. Much more drastic action would no doubt be necessary to exterminate mosquitoes and gnats locally, but there seems good reason to anticipate that the simple measures proposed may be successful in minimising an undoubted nuisance.

## EYESIGHT AND NAVIGATION.

IN an address to the Royal Philosophical Society of Glasgow, published in the *Ophthalmological Review* for August last, Dr. A. Freeland Fergus gives a sympathetic criticism of the recent report of the Departmental Committee of the Board of Trade on Sight Tests in the Mercantile Marine. After emphasising the dangers of defective eyesight in those responsible for the safe conduct of the travelling public he considers some of the chief points in detail. On the whole he agrees with the conclusions of the committee on the much-disputed question of colour vision. His criticisms of the wool test are largely those of the committee itself, yet he agrees that the test has a distinct utility even though it be not free from pitfalls. The addition of a lantern test meets with his hearty approval, and he goes on to urge the "standardisation of the colours of the sidelights of ships and of their luminosities." By thus emphasising both colour and brightness or luminosity he shows that he has a proper appreciation of the difficult problem of colour defects, a point so often ignored by writers upon the subject. Such a standardisation did not come within the terms of reference of the committee, but we have no doubt that they would heartily approve of it. That it was brought to their notice is shown by Dr. W. H. R. Rivers's memorandum, which is found in the appendix to the report. The present time would appear to be favourable for bringing forward this very wise suggestion. We have at the present

moment meeting in London an International Conference on the Safety of Life at Sea. Unfortunately, its programme is probably over-full with other and perhaps more important items. Yet it is a matter of some weight and should be pressed forward. It is not so simple as it seems, and Dr. Fergus's own suggestions are open to criticism. The replacing of a green light by a distinctly blue-green is satisfactory in some cases where fog is little likely to prove troublesome; but the great absorption of the blue rays by fog seriously limits the utility of bluish lights. Dr. Fergus concludes his paper with some remarks upon the "form" sense, a term which he uses in a different meaning from most writers. We do not altogether agree with his views, but they are interesting if only as indicating that in the limit there is the same difficulty in divorcing the form-sense from the light-sense that there is in divorcing the colour-sense from the light-sense. We warmly recommend all who are interested in the subject to study this paper.

## URETERAL CALCULUS WITH PAIN GREATEST ON THE OPPOSITE SIDE.

IN the *Bristol Medico-Chirurgical Journal* for June Mr. C. A. Moore has reported a case of ureteral calculus with the curious anomaly of pain greatest on the opposite side. A man, aged 38 years, was admitted to hospital. His illness began three months before with frequency of micturition (every two hours by day and about three times at night). Three weeks later he began to suffer from a dull ache across the loins, but much worse on the right side. A month before admission pain was felt in the hypogastrium and along the urethra on micturition, especially towards the end. Three weeks before admission blood suddenly appeared in the urine. This gradually diminished until the urine was only faintly tinged, but generally a few drops of blood were passed towards the end of micturition. Just before admission the hæmaturia ceased, but the pain on, and frequency of, micturition continued. On examination a markedly tender spot was found just internal to the left anterior superior spine of the ilium. The kidneys could not be palpated, but there was marked tenderness when pressure was made on the loins, and the lumbar spine was somewhat rigid on stooping. Cystoscopy and rectal examination were negative. The urine was acid and contained a good deal of pus, but no blood corpuscles. At intervals of about a week the temperature rose to 102°–104° F. with a rigor, but no urinary symptoms occurred. Skiagrams showed a small shadow in a position corresponding to the pelvic part of the left ureter. In view of the doubt as to the side affected it was decided to explore both urinary tracts by median laparotomy. The right kidney was distinctly large but felt perfectly normal, as did the ureter. The left kidney was small, but felt normal. In the pelvic ureter, just outside the bladder, a small hard mass was felt. The median incision was closed and an extraperitoneal ilio-inguinal incision was made. The ureter was incised and a calculus was extracted. The incision was so inaccessible that no attempt was made to close it, and the abdominal wound was sutured with a drainage tube passing down to the wound in the ureter. Complete recovery ensued. A few months later the patient complained of a dull pain in the loins and frequency of micturition. A skiagram showed no sign of calculus, but the urine was swarming with bacillus coli. The chief interest of the case is the fact that although the calculus was in the left ureter the pain was chiefly in the right loin. Some years ago a theory originated by Thornton and Guyon was in vogue, the so-called reno-renal reflex, which meant that reflex pain might be caused in a healthy kidney by a calculus in its fellow. The possibility of this was denied by Sir Henry Morris, who held that pain in a healthy kidney never occurred except as an accompaniment of more severe pain in its fellow. At first sight reno-renal reflex seems to explain the pain in the right kidney in this case, for all the symptoms temporarily subsided with the removal of the calculus from the opposite ureter. However, the recurrence of slighter symptoms on that side on the onset of the bacilluria obscures the issue, as the pain might have been due to pyelitis produced by the colon bacillus. But Mr. Moore thinks that the possibility of reno-renal reflex cannot be wholly put aside, for stone in the upper part of the urinary tract may cause a reno-vesical reflex with hypogastric and perineal pain and dysuria when the bladder is perfectly healthy. The only way to settle the diagnosis seemed to be to explore both tracts through the abdominal wound.

## "DEFIXIONES."

THE votive offerings of classical times have attracted a good deal of attention. Less has been known until recently about the *defixiones*, or curses, which were a natural corollary of the conception of votive offerings. The means that are potent for good can always be diverted for evil. And the appeal to the gods to intervene and remove the punitive suffering they had inflicted on account of their own anger would naturally suggest in course of time that that anger might be set in motion against any personal enemy. Various methods of bringing this about have obtained in different ages and localities, but in Greek and Roman times a very interesting one was by means of imprecations written on tablets of lead or talc. The name defixiones results from the idea that the inscribed curses would fix down the person against whom they were directed. The word *defigere* was used with *pavor*, *stupor*, by classical writers to signify what we mean when we speak of someone being "rooted to the ground" with terror. A man might be *defixus dira imprecatione*, and that on which the curse was inscribed became metonymically a *defixio*. Specimens of these imprecatory texts have been found at various sites in Italy, Greece, and Asia Minor, and especially in Egypt, and several are to be seen in the British Museum.[1] A new collection of these Tabellæ Defixionum has recently been acquired from Rome by the Johns Hopkins University of Baltimore. They have been edited by Professor Sherwood Fox, of Princeton University. Not only are they of palæographical importance as specimens of Latin cursive script of the first century B.C., but they are also of great medical interest, seeing that the chief curses inscribed upon them consist in calling down various diseases, so that nearly every then known disease and vital organ of the human body is specified in them to ensure injury to the victims. A certain Avonius was

[1] A large number of *Tabellæ Defixionum* have been published by M. Auguste Audollent, and many more by Herr Richard Wünsch. It is to be noted that in the Latin of popular speech scant attention was probably paid to such grammatical niceties as case endings. The instances here given are quoted without alteration from Professor Sherwood Fox's memoir.

devoted "Febri quartanae, tertianae, cottidianae, quas cum illa luctent, deluctent; illanc euincant, uincant, usque dum animam eius eripiant." Consigning an enemy to various types of malaria has been noted in previously edited tablets of this description. Sentences such as "patiatur febris, frigus tortionis palloris sudores obripilationis meridianas interdianas," sometimes "nocturnas," and also the words "tercianas," "quartana," occur, but this is the first occasion in which "Febris cottidiana" is known to be alluded to. Upon a Greek curse we read καὶ φρίκη καὶ καθ' ἡμέραν καθημερωῖ πυρετῶ. We refer particularly to these texts because of the light they throw upon modern theories concerning the effects of malaria upon both Greek and Roman history. The summary of the bodily organs and members given in these new-found leaden plates is tolerably complete, the total list of human members and faculties amounting to 49. Many of these are enumerated because their functions are specially invoked, or magically compelled to become dormant, or entirely blasted. Thus the ocular "pupillas" and "palpebras" are referred to in the hope that the victim "ni possit ..... aspicere, uidere, contemplare." The intestina, latera, and "scapulas"—front, sides, and back—are defixed "ni possit sanus dormire"; also the "uiscum sacrum" in connexion with the favourite desired disability, "nei possit urinam facere." The buttocks also and parts of the legs are defixed "ne possit stare." To make the curse potent, not only "natis crura," the legs below the knees, the femora, and genua, but the tibias, pedes, planta, digitos, and ungis are enumerated in different grammatical cases according to the context. Sometimes a series of contiguous or adjacent parts are defixed in a group, as by such a sentence as "cellus, os, bucas, dentes, labiis, mentus, oclos, fronte, supercili." The nose, tongue, fingers, neck, chest, lungs, arms, umbilicus, anus, head, and other parts are defixed. Relative to the possible prevalence in Roman times of any diseases analogous to syphilis it is interesting to note that no such malady for the sexual organs is even suggested. The ancestors of these tabellæ are to be traced in the imprecatory cuneiform tablets of Mesopotamia.

## THE VARNISHED FROG.

IT was formerly held by physiologists, who sought for an explanation of the death of amphibious animals which had been subjected to the process of varnishing, that the fatal result was caused by retention of the products of cutaneous secretion and consequent toxæmia. Dr. Vittorio Puntoni, of the University of Bologna, has recently conducted a series of experiments on varnished animals with a view to ascertain the effect of this process on the digestive system and the intestinal micro-organisms. His results, which have been recorded in the *Bollettino delle Scienze Mediche*,[1] seem to show that death from suppression of the cutaneous function is not due solely, as many observers have affirmed, to a progressive cooling down of the organism, but also to toxic and nervous factors. Even modifying the value of these toxic and nervous factors, the conception of "death by cooling" should be expressed more accurately by "death from disturbance of heat regulation." The fact is that the cooling of varnished animals takes place only if they are kept in surroundings of a lower temperature than that of their body, while if they are kept in a warm atmosphere of 38° C. or more death occurs from hyperpyrexia. Dr. Puntoni found that the interference with the function of the skin, besides acting generally on the whole organism, had a particularly injurious effect on the stomach and small intestine, and produced changes in the normal intestinal flora consisting of a bacterial auto-depuration of the bowel and variable modifications in the virulence of B. coli. The intestinal wall in varnished animals becomes permeable to micro-organisms of a pathogenic nature when artificially introduced. Thus B. anthracis, free from spores, is able to infect the organism through the intestines and reproduce the disease; B. typhosus passes into the circulation, an interesting fact, since typhoid fever is not a disease having its seat in the intestine, but a general infection due to the penetration of the specific agent into the general circulation and lymph organs. Also the cholera vibrio, which usually has but little affinity with the blood plasma, is able to pass under these conditions through the intestinal barrier and multiply in the blood. The passage into the circulation of micro-organisms in general and of the cholera vibrio in particular, is in relation not only with lesions in the intestinal wall but also with changes in the bactericidal power of the blood serum, which is markedly lessened. These conclusions have an eminently practical interest in their relation to certain natural conditions, such as the deleterious effects of moist, warm climates and the use of improper clothing, which act by disturbing the cutaneous function. In fact, by experimentally subjecting animals to the action of moist heat, the same effect is observed as in animals varnished and kept in a temperature of 38°–39° C., and an explanation is thus found of the action of natural conditions in predisposing to gastro-intestinal affections, whether ordinary or specific.

[1] Anno 84, Serie 9, vol. i. Bologna, Tipogr. Gamberini e Parmeggiani, 1913.

## SPINAL INJURIES DUE TO SKI-JUMPING.

THE first sight of a ski-jumper rushing through space at an almost incredible speed naturally conjures up in a spectator's mind a picture of bruises and fractures at the end of the performance. Yet these are extraordinarily rare, largely because the force with which the jumper strikes the ground is chiefly spent in carrying him further down the hill. On this account a hill is selected down which the jumper can expend his momentum after he has completed his jump. In Germany the accidents which may follow ski-jumping have been frequently described, but fracture of the spine has not, apparently, hitherto been observed. Even in Norway, the birthplace of this performance, the following lesions described by N. B. Gröndahl in *Norsk Magazin for Laegevidenskaben* for August, 1913, have not been observed earlier. The patient was an athletic man, aged 30, who jumped a distance of 15 metres from the point where he left the ground to the point where he alighted. After he had alighted the momentum of the jump carried him rapidly further down the hill. At some distance from the point of alighting he lost his balance and, falling backwards, he struck his right buttock against a lump of ice lying on the snow. He did not touch the ground with his back. After a brief interval of unconsciousness he was helped home. Here he felt fairly well in spite of some stiffness

and a hæmatoma as large as a child's head on the right buttock. The thoracic vertebræ were not tender, and compression of the spine by pressure on the shoulders and head caused no pain. Pressure at a point between the vertebral column and the angle of the right scapula did, however, cause pain. After a week's rest the patient returned to his work, during which he noticed a slight "girdle" sensation along the costal margins. There was no other peripheral symptom, but a careful examination of the thoracic vertebræ revealed slight scoliosis, with the concavity of the spine facing towards the right. At this level a dorsal spinous process showed slightly abnormal prominence, but was hardly tender. A skiagram showed a slightly slanting, transverse fracture of the body of the ninth thoracic vertebra, and an oblique fracture of the right transverse process of the seventh thoracic vertebra. The scoliosis was evidently due to the body of the ninth thoracic vertebra being more compressed along the line of fracture on one side than on the other. A plaster-of-Paris splint was applied, and the patient kept in bed for three and a half months. A leather corset was subsequently applied so as to support both neck and arms. A year later the appearance of the spine was unaltered, but there was no longer any tenderness. There can be little doubt as to the mechanism of this injury. The patient was convinced that he had not directly struck his back when he fell, and there were no bruises over the spine. It is evident that when he suddenly sat down with great violence on his right buttock the force of the blow was conducted up the spine, and the fracture occurred at the junction of the rigid with the relatively mobile part of the spine. This was thrown forward, while the lower part of the spine was practically fixed. The obliquity of the fracture of the body of the vertebra was probably due to the blow being limited to only one buttock. It is strange that this accident is not more common.

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## THE GREENLAND VIKINGS AND THE WHITE ESQUIMAUX.

To medical men the death or decay of white races in hot or distant climates is not less interesting than the degeneration of a family or of individuals. The "Poor Whites" of the West Indies, who are the decadent descendants of Cavaliers sent into slavery by Oliver Cromwell, survive lugubriously, pathetic representatives of a once high-hearted class; but other white races have completely disappeared, leaving behind them only a ruin or two, a few graves, a tradition vaguely repeated by savages, an occasional racial cast-back among yellow or dark-skinned supplanters. We are thinking more particularly of the Norsemen of southernmost Greenland, who flourished for some 300 years, then fell into decadence, and utterly disappeared towards the close of the fifteenth century. History records that in about the year 985 A.D. Eric Raudi, the Red or Ruddy, an Icelandic outlaw, founded two colonies, Wester and Oestre Bygd, to the west of the southern cape of Greenland, a name of hopeful sound adopted by him to attract colonists. Eric the Red is a pioneer among European explorers. Though a pagan, he seems to have been a singularly good man, and he was a careful explorer. It was his son Leif who is credibly supposed to have discovered "Vine-land the Good," or America, with which his people afterwards traded. They constituted, in fact, a flourishing trading republic, keeping up their connexion with Bergen and with Iceland for centuries. In 1448 a fleet of "heathen," supposed to be English, attacked them. Then in successive waves they were invaded from the north by the Esquimaux, at that time ferocious, and by the Black Death from overseas. Their connexion with Europe ceased, and though in 1492 an effort was made to reopen communications with them nothing came of it. In 1496 a bishop, appointed to the Greenland see, sailed, but could not reach it. The last of their bishops died in Europe in 1540. He had never visited them. Their civilisation probably flickered out after 1450. "Darkness falls," says Mr. William H. Babcock, their latest historian, "but the uncertainty and the marked pathos of this chapter of old history makes any item (of information) very welcome." One such item is a mysterious story of voices, for the colonists were perhaps *heard*, though not seen, by an Icelandic bishop, Amund of Skalpolt, in the sixteenth century, who was driven by stress of weather so close in shore that his ears caught, or he believed so, from the deck of the ship voices of Norsemen on some track near by, and the passage of cattle and sheep. This was at Heriulfsness, now an Esquimaux settlement with an Esquimaux name. The voices from the shadow were the last sign of life given by perhaps the earliest European colonists, forerunners of Columbus. In 1585 John Davis, the explorer, found their settlements in the hands of the Esquimaux, who retained a few dim traditions of white men. They had left behind them a fourteenth-century church (the cathedral of Gardar), some 17 ancient houses, one of which, from its decorations, has been identified as that of Eric the Red, and a few coffins containing European corpses, with faces wrapped in coarse antique cloth. In 1721 the "Apostle of Greenland," Hans Egede, made determined efforts to find "the lost people" along certain green inland fiords beyond the ice-wall of the coast. Southern Greenland, it should be remembered, has the climate of Iceland or of Northern Norway. He found nothing, nor did a subsequent explorer, Lieutenant Holm, in the last century. Recently, however, Herr V. Stefansson has reported the existence of white Esquimaux on Coronation Gulf, far to the north of the original Icelandic settlements. It is said that some of these tribesmen have light hair and that their language contains Norse words. Romantic as this may seem, it is not impossible nor yet improbable. Disease, the mediæval Black Death, may very well have decimated the ancestors of these people, and their weakened remnant may have been absorbed by invading savagery and carried northward. Many instances are recorded of similar absorptions. An Indian town in Chili, to take one case, is known to be mainly descended from Spaniards, who there held a fortress, erected by a viceroy for the purpose of overawing the natives. The Norse Greenlanders in their day produced the "Lay of Atli," and perhaps contributed to the verse Edda. They thus formed part of the grand literary movement, which in Iceland produced the "Prose Edda," that sublime and little-known poem. To the scientific psychologist the mental changes taking place in a vanishing race are as interesting as physical decay to the pathologist. When did these white Esquimaux, supposing them to be descendants of Norsemen, begin to forget their traditions and their

origin? And who among them was the last to remember that he was of a white race?

## THE AMERICAN COLLEGE OF SURGEONS.

THE first congregation of the American College of Surgeons was held on Nov. 13th at Chicago, when Sir Rickman Godlee, Bart., President of the Royal College of Surgeons of England, gave an address, which is published in full in another column. On behalf of the Council of his College Sir Rickman Godlee presented the following address of congratulation:—

We, the Council of the Royal College of Surgeons of England, have heard with much interest of the approaching inauguration of the American College of Surgeons. We hereby convey to it our hearty good wishes, and express the hope that it may have a successful career and fill a position beneficial alike to the profession and to the community. We cannot forget the important advances in the science and art of surgery achieved by many distinguished surgeons in the continent of America during the past, and are proud to have enrolled upon our list of Honorary Fellows the names of the most active workers in these fields at the present day.

The address, which was countersigned by the Vice-Presidents of the College, concluded with a vivid appreciation of the value to English-speaking peoples which a professional bond between our surgeons and those of America must be.

THE King, on the recommendation of the Home Secretary, has appointed Mr. W. H. Dickinson, M.P., and Mrs. Pinsent to be Commissioners (unpaid) under the Mental Deficiency Act, 1913.

THE Royal Society, with the approval of the King, has awarded a Royal medal to Professor E. H. Starling, M.D., for his contributions to the advancement of physiology, and the Copley medal "for the high scientific value of researches in zoology" to Sir E. Ray Lankester.

THE Waynflete Professorship of Physiology in the University of Oxford, vacant through the lamented death of Professor Francis Gotch, has been filled by the appointment of Dr. Charles Scott Sherrington, F.R.S., Holt Professor of Physiology in the University of Liverpool. Professor Sherrington's distinguished record of scientific work in London, Liverpool, and Cambridge makes him a worthy successor to the chair held in turn by physiologists of the eminence of Burdon-Sanderson and Gotch.

AT the London Chamber of Commerce on Nov. 13th, Mr. Austen Chamberlain presiding, it was announced that the fund raised by the City subcommittee in aid of the London School of Tropical Medicine amounted to £71,444, of which, after deduction of expenses, £70,430 would be available for the school. It was decided that the fund should be formally closed and the subcommittee dissolved.

UNIVERSITY OF LONDON: AWARD OF UNIVERSITY MEDALS.—University medals in connexion with the M.D. and M.S Examinations for Internal and External Students, July, 1913, have been awarded as follows: University medal in Branch I. (Medicine) of the M.D. Examination to Charles McMoran Wilson, B.S. (St. Mary's Hospital); and University medal at the M.S. Examination to Geoffrey Jefferson, M.B. (Victoria University of Manchester).

## THE INTERNATIONAL CONFERENCE ON TUBERCULOSIS.

(FROM OUR BERLIN CORRESPONDENT.)

THE Eleventh International Conference on Tuberculosis was opened in Berlin on Oct. 22nd in the great hall used for the sittings of the Prussian Diet. The President of the International Anti-Tuberculosis Association, M. Bourgeois, of Paris, being on account of the state of his health unable to attend, the chair was taken by Dr. Bumm, chief of the Imperial Health Office in Berlin. Professor Pannwith, the honorary secretary of the Union, acted as secretary. H.M. the German Empress was present at the first meeting, together with a numerous audience, including prominent medical men from Germany and abroad. The British visitors consisted, among others, of Professor T. Shennan (Edinburgh), Dr. D. Barty King (London), Dr. N. Raw (Liverpool), and Dr. H. de C. Woodcock (Leeds).

The inaugural address was delivered by the Secretary of State, Dr. DELBRÜCK, who gave a report on the work done in this country and abroad for the combat against tuberculosis. He said that during the last 15 years the mortality from tuberculosis had decreased one-third in England, France, Belgium, Germany, and the United States of America, and one-fifth in Austria, Switzerland, and the Netherlands.

*Pathogenesis of Tuberculosis.*

The first subject of discussion concerning tuberculosis in man was introduced by Professor LANDOUZY (Paris). He said that tuberculosis was a reaction of the organism against the tubercle bacilli, according to the intensity of their virulence; social conditions, dwellings, and workshops were of fundamental importance. Clinical symptoms often depend on the age when the individual has contracted an infection and on the ways on which the bacilli entered the organism. The power of resistance differed in the various organs at different ages, as well as according to the patient's employment and mode of life. No one existed who was totally immune against tuberculosis; when anyone escaped infection it was not only by virtue of a disposition, but also in consequence of good external conditions by which the organism has been protected against the injurious influences which ordinarily led to infection.

Professor SHENNAN (Edinburgh) discussed some histo-anatomico-pathological alterations in the human body. He said that in Scotland the maximum of deaths from tuberculosis happened between the ages of 25 and 35 years, but in England between those of 35 and 45 years. In Scotland the mortality from tuberculosis was relatively greatest for women between 15 to 20 years, but for men between 20 and 25 years. In different Scottish towns no relation could be ascertained between the mortality from tuberculosis and the density of the population, so that other factors were likely to exist. Anaphylaxia from primary infections was very important for new infections, which, however, did not always originate from foci present in the body, but might come from outside. The majority of cases of tuberculosis of the lungs and the neighbouring glands were produced by infection from the external air. It was not possible to ascertain that an infection was conveyed from the lungs into the deeper cervical glands. The right lung and its neighbouring glands were more frequently the seat of tuberculosis than

the respective organs on the left side. In children tuberculosis of the lungs was, as a rule, the sequel of tuberculosis of the bronchial glands. Little was known of the causes of the lungs being the seat of tuberculosis.

Dr. HAMBURGER (Vienna) discussed the results obtained by experimental medicine in the study of tuberculosis, especially the discovery of (1) the infectious nature of tuberculosis; (2) the specific bacillus of the disease; (3) the fact that tuberculous infection usually took place through inhalation; and (4) the circumstance that most human beings contracted infection in childhood. It has further been proved by experiment that tubercle bacilli in a tuberculous patient succumbed under treatment with a specific solution, and that the bacilli if not killed might occasionally remain harmless in the human body. The tuberculous nature of many diseases of the bones, kidneys, glands, and skin could also only be proved by experiments on animals. The biological method was superior to the morphological one. It was probably unnecessary to emphasise the fact that the tuberculin treatment was based wholly upon experimental work.

*Surgical Treatment of Pulmonary Tuberculosis.*

The second subject discussed before the conference, that of the surgical treatment of pulmonary tuberculosis, was introduced by Professor BRAUER (Hamburg). He said that the surgical treatment in question might be divided into the treatment of the fundamental disease and of the complications and secondary symptoms. The prophylactic separation of the cartilaginous part of the first rib recommended for the prevention of pulmonary tuberculosis had not been extensively employed. The opening of tuberculous cavities was very seldom indicated and only in the case of cavities containing a large amount of putrid secretion. A valuable addition to the usual treatment was the artificial collapse of the lung by the operation for producing pneumothorax, an operation which has proved very effective when the selection of patients has been made with care and the operation performed in a correct manner. Adhesions of the pleura could be treated by extrapleural thoracoplasty. Partial collapse of the lung might be attained by freeing the adhering apex of the lung according to the method of Professor Tuffier, of Paris, who filled out the cavity resulting from the severing of the upper lobe by implanting surviving adipose tissue. Paresis of the diaphragm by cutting the nerve produced inaction of the lungs in their lower parts.

Professor TUFFIER (Paris) then described his method and gave technical explanations.

*Insurance Offices and the Prevention of Tuberculosis.*

Dr. FRANKEL (New York) reported how the New York insurance companies contributed to the prevention of tuberculosis by prophylactic measures and by providing adequate care and treatment for insured persons.

Dr. KAUFMANN, President of the Imperial German Insurance Office under the Workmen's Insurance Act, gave a report on the work of State insurance in a national combat. In 1912, 19·2 millions of marks were spent by the State insurance institutions on the care and treatment of more than 50,000 tuberculous patients. A principal feature of the sanatoriums was the giving of instruction in hygiene by which a knowledge of hygienic principles was spread among the great mass of the population. For dispensaries about 400,000 marks and for hygienic dwellings no less than 418 millions of marks were employed in loans. The first sanatorium for patients suffering from pulmonary diseases was erected in 1895; in 1902 there were 15, and at the end of 1912 there were 39 sanatoriums with 3512 beds for men and 1358 beds for women. In 1912 over 50,000 patients suffering from pulmonary diseases were treated at an expenditure of £960,000. Of the patients successfully treated in 1907 there were at the end of 1912 57 per cent. still capable of earning their living. For sheltering patients suspected of tuberculosis, patients in the first stage, in whom no bacilli have been found, and patients with latent tuberculosis convalescent homes in forests have been established by the insurance institutions. Besides the curable tuberculous patients special care was bestowed on those suffering from advanced tuberculosis, who were removed to special institutions so as to prevent them from infecting their families. The recent law concerning the insurance of widows and orphans now authorised the insurance institutions to place orphaned pensioners in an orphanage or some similar establishment, and thus there was a possibility of extending the care of the insurance institutions to children threatened with or already attacked by tuberculosis. Special sanatoriums existed also for the treatment of lupus and of tuberculosis of the bones and joints. The developments of the last ten years showed a steady and systematic progress, so that the prevention of tuberculosis as an endemic disease was no longer a mere dream.

*Schools and Workshops for Children Liable to Contract Tuberculosis.*

The last subject on the official programme was that of schools and workshops for children liable to contract tuberculosis. Professor Blumenthal (Moscow) and Dr. Chaptal (Paris), who had been announced as the speakers, did not appear, so that the introductory address was delivered by Dr. FRANZ, one of the directors of the Red Cross sanatorium in Hohenlychen. He said that young people at the age of puberty suspected of tuberculosis were very liable to develop the disease when they began to work at a trade. For such cases it was necessary to establish schools and workshops in which trades were taught and in which the preparation for the respective trades was conducted with due attention to hygiene and the strengthening of the juvenile organism. These institutions should be the continuation of the sanatoriums for children and should eventually be connected with them. Such schools existed already in Hohenlychen, and included an agricultural and gardening school, a school for needlework, and a model printing office.

*Other Papers.*

The subjects and authors of the non-official papers read before the conference were as follows:—Sanatoriums for the Middle Classes, by Dr. FRANZ (Berlin); Compulsory Notification of Tuberculosis, by Dr. GLASENAPP; the Influence of Women in the Prevention of the Disease, by Madame MONMERON-TISSOT (Lausanne) and Dr. GUINARD (Paris); Tuberculosis among School Teachers, by Dr. ALTSCHUL (Prague); the Power of Resistance among the Tuberculous, by Dr. WOODCOCK (Leeds); Official Statistics of Tuberculosis, by Dr. BEHLA (Berlin); Public Measures for the Prevention of Tuberculosis, by Dr. N. RAW (Liverpool), published in THE LANCET of Nov. 8th

(p. 1316); and many others which exigencies of space prevent from being mentioned in detail. In the final meeting reports on the progress of the campaign against tuberculosis were delivered by representatives of the various countries. The social entertainments in connexion with the conference included a dinner at the restaurant of the Zoological Garden, a banquet given by the city of Berlin, and a gala performance at the Royal Opera.

It was decided that the next conference shall be held at Berne.

## MEDICINE AND THE LAW.

*The Children Act, 1908, and a Parent's Refusal to have Adenoids Treated in a Child.*

IN the Divisional Court, upon a case stated by magistrates at Melton Mowbray, the question to be decided was whether upon the facts set out by the magistrates they were obliged to hold, as they had held, that the respondent, the father of a girl 13 years of age, was under no legal liability to have her operated on for the removal of adenoids, and that the refusal to allow such an operation to be performed did not constitute neglect to provide medical aid within the meaning of the Children Act, 1908, Section 12, Subsection 1. Among the points considered were the probable effect of adenoids, that the operation was not dangerous, and that the parents had refused it. The Divisional Court was asked to say whether the magistrates had come to a correct decision in law. The refusal of the father to allow his child to be operated upon was due to his opinion that an operation was not necessary and to his "not believing in operation," and that there was no other evidence of neglect of the child. The court held that the magistrates might properly have convicted, and that the case must go back to them to be reheard. Mr. Justice Darling, in his judgment, called attention to it having been found among the facts that adenoids caused deafness, which was one of the ailments specially provided against by the Act. The defendant had had the need of the operation brought to his notice, and the statute obviously contemplated operations. The fact that the parents did not believe in operations showed that they were persons whose opinions were of little weight, but refusal to allow an operation was not necessarily such a refusal to provide medical aid as to amount to wilful neglect. Mr. Justice Avory and Mr. Justice Atkin concurred, and the case was sent back.

*Bright's Disease and an Accident.*

In making a claim against the Sun Insurance Office in the Manchester county court recently Phœbe Wood, a widow, had to establish the fact that her husband, Charles Wood, died as the result of an accidental fall from a ladder in July, 1910, which had had as its consequence Bright's disease, from which she alleged that he died in January, 1913. Two medical witnesses, Mr. H. E. Edlin and Dr. C. Richmond, gave evidence to the effect that such a result in their opinion might follow upon a severe fall and had done so in the case of the deceased. On the other side Mr. E. D. Telford and Dr. E. N. Cunliffe could trace no connexion between the condition of Wood before his death and the accident which he had met with, the latter, who had seen him in September, 1912, saying that he was then suffering from chronic granular kidney which would have caused his death whether there had been an accident or not. The learned county court judge came to the conclusion that the accident had weakened the power of resistance of the deceased to the disease from which he suffered and made an award for the amount claimed by the widow.

*Medical Men summoned to Assist a Midwife.*

At a recent inquest on a woman who died after giving birth to a stillborn child the jury added to its verdict, which ascribed death to heart failure, a rider which charged three medical men with inhumanity because they had not attended when summoned by the midwife in attendance. One of the medical men, who had inquired for his fee, was especially criticised. We feel that coroners might in such cases as these well explain to juries the position of the medical man summoned on the advice of a midwife in accordance with her duty under the Midwives Act, when painful misunderstandings would be less frequent. That position continues to be as unsatisfactory as ever, or perhaps may be regarded as more so, for after boards of guardians had in many places arranged to compensate medical men in the circumstances indicated when they were unable to obtain payment from their patients, the National Insurance Act, 1911, Section 18, ordered that "the prescribed fee shall, subject to regulations made by the Insurance Commissioners, be recoverable as part of the maternity benefit." The Act of 1913, Section 14, however, repealed this provision, so that unless the board of guardians has reverted to its former practice, or has adopted the practice referred to since the Insurance Act, 1913, was passed, the medical practitioner has only the patient or the patient's relatives to depend upon for payment in attending cases almost necessarily of a difficult or serious character, and on behalf of which he is expected to disregard the claims of other patients.

## ROYAL COMMISSION ON VENEREAL DISEASES.

AT the first two meetings of the Royal Commission on Venereal Diseases, which were held on Nov. 7th and 10th, preliminary evidence was given by Dr. T. H. C. Stevenson, Superintendent of Statistics at the General Register Office, and statistical evidence as to the prevalence of venereal diseases in the Royal Navy was given by Surgeon-General A. W. May, the Director-General of the Navy Medical Department. Dr. Stevenson's evidence was concerned with the figures contained in the Annual Report for 1911 of the Registrar-General for England and Wales and related mainly to the question of the reliance which might be placed on those figures as indications of the prevalence of venereal disease in the country.

Dr. Stevenson thought that although the quality of certification generally was improving there undoubtedly existed a reluctance on the part of medical practitioners to certify venereal diseases as a cause of death and that consequently the figures contained in the Report were minimum figures. He agreed also that there were doubtless many cases of deaths indirectly due to venereal diseases which are not demonstrated by the tables of the Report. At the same time he considered that although the figures do not express the facts, they bear some relation to the facts, and must be regarded as having a distinct comparative value; for instance, he attached importance to figures showing that the death-rate from syphilis in London is four times as high as in the rural districts, and that in descending the scale from the densely populated to the rural districts the death-rate becomes progressively lower. Dealing with the question of

improving certification, Dr. Stevenson strongly advocated a general system of confidential certification under which certificates of the cause of death would not be handed over to the surviving relatives.

The Director-General of the Navy Medical Department gave figures extending over the period from 1905 to 1912. These figures showed evidence of decline both in regard to syphilis and to gonorrhœa. The figures of the number of cases and of the number of days lost through sickness for 1912 showed a far more accentuated fall as regards venereal diseases than for any other disease. The Director-General considered that the reduction in the figures might be due rather to the better education of the sailor in health matters than to the diminution in the prevalence of diseases in the ports. He thought that the men had absolute confidence in their medical officers, and that concealment of disease was practically non-existent. It is the practice in the navy for medical officers to give lectures on hygiene to the men, and this system was beginning to show very good results, and the Admiralty had great hopes of it. With regard to invalidings from the service on account of venereal disease the Director-General thought that the rather sharp fall in 1911 which was disclosed in the tables should be attributed to improved methods of treatment.

## ANNUAL REPORT FOR 1911 OF THE REGISTRAR-GENERAL.

WE have received the seventy-fourth annual report of the Registrar-General, the publication of which has been delayed in order that the results of the recent Census may be embodied. Containing as it does an abundance of statistical material never before accessible, this volume properly appears as the first of a new series. Apprehensive of the danger of sacrificing continuity with past records, the authors have taken pains in reconstructing the present series to preserve the means of comparison with all that is essential in the writings of their predecessors, whose researches are justly accredited as the basis of vital statistics in this country. The earlier reports of the Registrar-General are out of print, but a few complete sets are still available for reference. The first report, relating to the year 1837, is a thin octavo pamphlet, consisting of a brief commentary by Dr. Farr and a preface of 25 pages by the Registrar-General. The report for 1911 is a folio volume of 577 closely printed pages. In contrast with its predecessor of 1837 the increase in its size and importance is remarkable, corresponding, in some measure, to the advance of public opinion in sanitary matters which has marked the interval between these dates.

*The Administrative Area as the Unit of Tabulation.*

In the present volume full effect is given to the changes foreshadowed by the Registrar-General on his accession to office, and more fully discussed in his annual reports for 1909 and 1910. For official reasons postponement of these changes until the opening of a new decennium appears to have been unavoidable, but the fact that the several improvements promised in previous years have been fully achieved goes far to make amends for the late appearance of the present report. Fully recognising that the value of statistics is enhanced by their timely publication, the Registrar-General intimates his regret that, owing to the heavy labour imposed upon his small staff by its preparation, the presentation of this report has been so long delayed; but he expresses the hope that, special arrangements for that purpose having been completed, the annual reports of future years will be published not later than the autumn of the year succeeding that to which they severally relate.

The primary change now accomplished, upon which future improvements must mainly depend, and for which the necessity has been urged by Mr. Mallet's predecessors, not less forcibly than by himself, is that of the substitution of the administrative for the registration area as the unit for the tabulation of births and deaths, so as to bring the statistical returns of the local health officers into line with the national records of Somerset House. This is a boon the attainment of which will be appreciated by every member of the Public Health Service, as well as by the sanitary authorities of the country. Eventually it may pave the way for a closer official relation between the National Register Office and the medical department of the Local Government Board—a development which for obvious reasons is greatly to be desired.

Consequent on the adoption of the administrative area as the local unit of tabulation is the necessary change in the size and subject matter of the report. The transference from one set of areas to another has led to practical difficulties which have only been overcome by a system of mechanical card-sorting and counting. The new areas are thrice as numerous as the old, and this involves a corresponding increase in the labour required. Moreover, the use of the card system has materially extended the possibility of tabulation so that much additional information is now accessible, the mere abstraction of which, under the discarded "ticking system," would have been impracticable. These factors in the aggregate have so greatly increased the material to be dealt with as to necessitate the alterations referred to.

*Changes in Natality and Fertility.*

In the year 1876 the English birth-rate attained the highest point on record—viz., 36·3 per 1000 living, since which date the ratio has fallen almost steadily from year to year. Stated in terms of total population, the rate of birth obviously depends on the proportion of females of conceptive ages in the population, and on the proportion of these that are married. In an interesting table these proportions are set forth for the last five Census years. From this it appears that the proportion of women of conceptive ages who are married was higher in 1911 than in 1901, but the proportion of these married women at the earlier ages had fallen. This change was almost certainly due to postponement of marriage, which in itself must appreciably affect the birth-rate, because fertility is known to diminish rapidly with advancing age.

Taking as a standard the mean annual birth-rate in the quinquennium 1876–80 the fall in the birth-rate since that period amounts to 31 per cent.; the fall in the proportion of births to the number of women of conceptive ages amounts to 36 per cent.; whilst the fertility of married women—i.e., the ratio of legitimate births to wives of conceptive ages—showed a decrease of 34 per cent. If the fertility of married women in proportion to their numbers had been as high in 1911 as in 1876–80, the legitimate birth-rate would have been 35·2 per 1000, or 11·8 in excess of that shown in the tables. Locally the birth-rate varies considerably. The highest rates are recorded in Wales, the next highest in the north of England, whilst those of the south are by far the lowest; and were it not for the inclusion of London in the southern area the rate there would be below that obtaining in any other area of the country. The high position of Wales and of the northern rural districts is doubtless due to the unusual proportion of miners there included, for mining counties everywhere return high birth-rates.

With respect to fertility Wales comes first, followed in order by the north, the midland, and the southern division of the country. The highest fertility rates obtain in the small towns of Wales, and the lowest in those of the south of England. London fertility takes a higher position than the remainder of the south of England.

*Vital Statistics of Administrative Areas.*

Among the new features in the present report the following may be mentioned as specially serviceable to medical officers of health. For the first time a summary is provided of the vital statistics of every administrative area in the country, so that the reader may ascertain the chief facts of natality and mortality for each locality in a form that is not only complete in itself, but also strictly comparable with like facts for other localities, the same rules and conventions of tabulation having been applied universally. At the request of the Society of Medical Officers of Health factors have been calculated for correcting or standardising the general death-rates of all the administrative areas in the country, and these factors are now published in a table, together with the standardised rates obtained by their use. And as these rates have been calculated with due allowance for age and sex differences of population they may be compared with confidence. For the more important areas—e.g., counties and county boroughs—an analysis is given of the deaths by cause and age in combination, as required by the forms issued to health officers by the Local Government Board. In order to economise space the deaths in the less

important areas are classified by sex and cause, but not by age. Particulars are not given of the mortality from the many thousands of death-causes specified in the tables for smaller areas, but with a view to afford inquirers the means of making such calculations estimates of the several populations are included in the published tables.

*Urban and Rural Areas.*

The Registrar-General again accentuates the caution, frequently uttered in these columns, against the too common practice of comparing statistical data which are in their nature incomparable. In respect of mortality the dwellers in towns are at a disadvantage as compared with those in the country; and as the counties contain urban and rural areas in varying proportions they do not form strictly comparable areas, either singly or in combination. Speaking generally, the urban areas included in the counties represent the smaller and the county boroughs the larger towns of England, while London stands alone as representing an exceptional type of city development. Three grades of urban area have now been established, and these with the rural areas make up the four great divisions of territory adopted in the new series of reports of the Registrar-General. For each of the divisions tabulation in great detail has been carried out, so that the effects of local conditions may be measured with precision, whereas hitherto only rough approximations have been possible. As an illustration of the manner in which estimated populations may be applied to deaths, so as to afford legitimate contrasts of mortality, the comparison now made for the first time between the before-named divisions of England will be found useful and suggestive.

*Occupation of Parents and Infant Mortality.*

The classification of infant mortality according to the occupation of parents is an instance of the use for the first time of information that has long been available. In order to compare the fertility of those engaged in different occupations all the births registered in 1911 have been tabulated according to the occupation of the parents—of the father in the case of legitimate and of the mother in the case of illegitimate children. In the forthcoming decennial supplement the results will be published as an addition to the ordinary tables of occupational mortality. From this and other sources in conjunction the Registrar-General anticipates that our knowledge of the causes and conditions of mortality among young children will be materially extended.

*(To be concluded.)*

## ROYAL COLLEGE OF SURGEONS OF ENGLAND.

MEETING OF COUNCIL.

AN ordinary meeting of the Council was held on Nov. 13th, Mr. G. H. MAKINS, Vice-President, being in the chair.

The SECRETARY reported that the President, with the object of fulfilling his undertaking to attend the first annual congregation of the American College of Surgeons at Chicago, left England on Oct. 25th, and expected to be back in London on Dec. 8th.

The SECRETARY reported the death on Oct. 22nd of Dr. J. Lucas-Championnière, an Honorary Fellow of the College, and stated that the President had written to the widow to express the sympathy and condolence of the Council.

It was resolved to grant Diplomas of Membership to 102 successful candidates.

In accordance with the recommendation of the Discipline Committee, the name of a former Member of the College which had been removed was restored to the roll of Members.

It was resolved to grant to the University of London the use of the College lecture theatre for lectures on the Cultivation of Animal and Vegetable Micro-organisms, to be delivered by the superintendent of the Brown Institution in December.

The SECRETARY reported that the Bradshaw Lecture would be delivered by Mr. G. H. Makins on Friday, Dec. 5th, at 5 P.M., and that the subject of the lecture would be Gunshot Wounds.

The senior VICE-PRESIDENT reported that Mr. W. G. Spencer's term of office on the Court of Examiners would expire on Dec. 10th, and that the vacancy thus occasioned would be filled at the ordinary meeting of the Council on Dec. 11th. Mr. Spencer is eligible for re-election.

The SECRETARY reported the notices of motion for the annual meeting of Fellows and Members on Nov. 20th.

## REPORT OF THE SANITARY COMMISSIONER WITH THE GOVERNMENT OF INDIA FOR 1911.

THE present report is submitted by Major J. C. Robertson, I.M.S., who assumed charge of the Sanitary Commissionership with the Government of India on May 17th, 1912, and deals with the calendar year 1911. The general discussion on the meteorology of the year, which formerly introduced the report, is now omitted; but the principal meteorological elements are furnished in an appendix, and in Section III. the main facts of importance are briefly summarised. On the whole the year 1911 was drier than usual, the total average rainfall of India having been about 3 inches (6 per cent.) below normal, due to the weakness of the monsoon. The highest rainfall occurred at Akyab, on the Burmese coast, where the total precipitation reached 209·5 inches, being 18·5 inches above the average; of this quantity 67 inches fell during August, being 23·8 inches above the average for the month. The highest temperature recorded was 119·2° F. at Peshawar in June; in the same month 118·3° was registered at Multan.

*Health of the European Army in India.*

The average strength of the European troops in India (excluding officers) during 1911 was 72,371. Of this force the admissions to hospital numbered 524·7 per 1000; there were 28·8 per 1000 constantly sick in hospital, 4·89 per 1000 died, and 7·12 per 1000 were invalided home. All these ratios were considerably below the preceding quinquennial average (1906–1910), and all, except the death-rate, were below those for 1910. The slight increase from 4·66 to 4·89 in the mortality was due chiefly to heat-stroke and cholera. For the first time on record enteric fever has not shown itself to be the most fatal disease for British troops, having caused only 0·33 deaths per 1000, while 0·46 per 1000 was due to hepatic abscess.

The forces in India are divided into a Northern Army, having a strength of 37,715, with divisions at Peshawar, Rawal Pindi, Meerut, and Lucknow, and three brigades on the Afghan frontier; and a Southern Army numbering 32,059, with divisions at Quetta, Mhow, Poona, Secunderabad, and in Burma, also a brigade at Aden. The admission rates for the two armies have been respectively 540·3 and 529·7, and the death-rates 5·54 and 4·27 per 1000. The chief causes of sickness in the Northern Army were malaria (86·1 admissions per 1000), sandfly fever (33·6), pyrexia of uncertain origin (32·3), and venereal disease (47·3). In the Southern Army malaria caused 99·9 admissions per 1000, and venereal diseases 61·9; while for sandfly fever there were only 3·9, and for uncertain pyrexia only 20·6 per 1000. Enteric fever caused 0·34 deaths per 1000 both in the Northern and the Southern armies; for cholera the death-rate was 0·45 in the former body and 0·12 in the latter.

On comparing different parts of India as regards the total amount of sickness—that is, the number of men constantly sick in hospital, we find the Burma inland group of stations (Mandalay, Shwebo, &c.) holding the highest place with a ratio of 37·4 per 1000, while in the Deccan the ratio was only 27, and in Burma Coast 26·5 per 1000. The admission rate was highest in the North-West Frontier, Indus Valley, and North-West Rajputana group of stations (830·9), and lowest in the Deccan (428·9 per 1000). The individual stations that have been most conspicuous for sickness have been Peshawar, with an admission ratio of 1219 and 40·4 constantly sick; and Attock, with corresponding ratios of 1154 and 30·1; Thyetmyo, Benares, and Nowgong had admission ratios of over 800 per 1000 strength. On the other hand, for Belgaum the admission ratio was only 296, for Kirkee 330, and for Secunderabad 355; the constantly sick ratios for these three stations being 20·6, 26·2, and 25·5 respectively. The large stations that are unhealthy are practically all in the Northern Command, while the large

stations of the Southern Command are practically all healthy.

*Principal Diseases.*

The year under review was on the whole healthy, and malarial fevers were less prevalent than usual. The admission ratio was 90·2 per 1000, as compared with 132 per 1000 in 1910. In addition there were 26·4 admissions per 1000 for pyrexia of uncertain origin, and 19·2 for sandfly fever, the corresponding figures for 1910 having been 37·7 and 7·1. Malaria prevailed most at Bellary (301 admissions per 1000), Mhow (251), and Peshawar (206), but these ratios are comparatively low. Antimalarial measures are being actively carried out by mosquito brigades, with systematic quinine administration, each man having a malarial case-sheet, and the treatment being continued until he is free from infection.

For enteric fever the number of cases that have been admitted is the lowest on record. Throughout the whole of India only 170 cases were admitted, with 22 deaths, the ratios per 1000 being 2·30 and 0·30 respectively. There were in addition 104 cases of paratyphoid fever with 2 deaths. There were no large outbreaks of enteric fever, the greatest number of cases in any one unit being 11 in the Norfolk Regiment. The disease occurred mostly as isolated cases, and there was no evidence pointing to drinking water, milk, or any food article as being the cause. At Lucknow there were 38 cases during the year, 28 occurring during February, March, and April. At Bareilly 26 cases were admitted, of which 22 occurred during January, February, and March; these were the nearest approaches to epidemic prevalence recorded, but no explanation is given of these outbreaks, as might have been expected. Paratyphoid fever occurred in 29 units, the largest number of cases in any one being 14 in the Royal Scots at Bareilly. Great care is now being taken in the detection of the disease, and the number of cases diagnosed is likely to increase, while the admissions for "pyrexia of uncertain origin" will diminish. The diagnosis by serum reaction is complicated by the fact that nearly all of the patients have been inoculated against enteric fever. The earlier work of Major Harvey and Captain Wood, of the Royal Army Medical Corps, showing the value of the absorption method in determining the true nature of the infecting organism has been developed and confirmed. Steady progress has been made with inoculation, 85 per cent. of the European troops in India having now been inoculated. Comparing the incidence of enteric in the two bodies of men, we find that among the inoculated the admission ratio has been 1·7 and the death ratio 0·17 per 1000; while in the non-inoculated these ratios have been 5·9 and 1·15 respectively. The case mortality ratios have been 10·37 and 17·18. Anti-enteric inoculation appears to give little protection against paratyphoid fever, and the use of a bivalent emulsion is suggested. Reinoculation against enteric after a lapse of two and a half years is being steadily advocated. The enteric fever hill depôts at Naini Tal and Wellington have been of the greatest service; convalescents from uncertain types of pyrexia are now sent to these depôts; and at Naini Tal Captain J. L. Wood found five out of 138 cases to be excreting the paratyphoid bacillus A. The excellent suggestion is made that early blood culture, from second to fifth day of disease, should be systematically carried out. Only by such procedure "will there be any hope of reducing the chaos which surrounds the pyrexias of short duration in India, and of arriving at the true facts concerning the precise prevalence of enteric and paratyphoid infections." In regard to carrier cases, 12 were detected in 85 paratyphoids, but not one in 95 enteric cases at Naini Tal. The use of an autogenous bacillary emulsion for the treatment of carriers, which in the previous year appeared to be most promising, has been found to be inoperative both at Naini Tal and Wellington.

Increased accuracy of diagnosis has probably been the chief reason for the return of 1393 cases of sandfly fever during 1911, compared with 512 in 1910.

The diminution in venereal disease amongst the troops has been as marked, and possibly as important, as the decrease in enteric fever. During 1911 the admission-rate was only 53·1 per 1000. This is to be compared with 58·9 in 1910, 80·7 in the quinquennium 1906–1910, and 273 in 1897–1906. As in the previous year, the Sanitary Commissioner records that this remarkable reduction is due to the coöperation between combatant and medical officers, chaplains, the Royal Army Temperance Association, and the men themselves. There was as usual considerable difference in the incidence of these diseases in different parts of the country, the admissions per 1000 numbering 114·8 in Burma (excluding Rangoon), and only 46·5 in the Upper Sub-Himalayan group of stations (Meerut, Umballa, Rawal Pindi, &c.).

*(To be concluded.)*

# VITAL STATISTICS.

## HEALTH OF ENGLISH TOWNS.

In the 96 English and Welsh towns with populations exceeding 50,000 persons at the last Census, and whose aggregate population at the middle of this year is estimated at 17,852,766 persons, 7974 births and 4738 deaths were registered during the week ended Saturday, Nov. 15th. The annual rate of mortality in these towns, which had been 13·1, 13·9, and 13·3 per 1000 in the three preceding weeks, rose to 13·8 per 1000 in the week under notice. During the first seven weeks of the current quarter the mean annual death-rate in these towns averaged 13·7, against 13·6 per 1000 in London during the same period. Among the several towns the death-rate last week ranged from 6·1 in Enfield, 6·9 in York, 7·0 in Swindon, 7·5 in Acton, and 7·7 in Oxford, to 19·3 in South Shields, 19·4 in Rotherham, 21·2 in Rochdale, 22·3 in Dewsbury, and 23·7 in Middlesbrough.

The 4738 deaths from all causes were 177 in excess of the number in the previous week, and included 380 which were referred to the principal epidemic diseases, against numbers declining from 925 to 435 in the five preceding weeks. Of these 380 deaths, 187 resulted from infantile diarrhœal diseases, 63 from diphtheria, 43 from measles, 36 from scarlet fever, 35 from whooping-cough, and 16 from enteric fever, but not one from small-pox. The mean annual death-rate from these diseases last week was equal to 1·1, against 1·5 and 1·3 per 1000 in the two preceding weeks. The deaths of infants (under 2 years of age) attributed to diarrhœa and enteritis, which had steadily decreased from 769 to 261 in the five preceding weeks, further declined to 187 last week; of this number 58 were registered in London, 14 in Birmingham, 10 in Liverpool, 8 in Middlesbrough, 7 in Manchester, 7 in Hull, and 6 in Sheffield. The deaths referred to diphtheria, which had been 38, 51, and 46 in the three preceding weeks, rose to 63 last week, and included 16 in London, 3 in Nottingham, 3 in Cardiff, and 2 each in Tottenham, Cambridge, Bristol, Stoke-on-Trent, Manchester, Salford, and Preston. The fatal cases of measles, which had been 27, 49, and 30 in the three preceding weeks, rose to 43 last week; 7 deaths occurred in Sheffield, 4 in Stockport, and 3 each in London, Birmingham, and Liverpool. The deaths attributed to scarlet fever, which had risen from 16 to 34 in the four preceding weeks, further increased to 36 last week, and included 6 in Birmingham, 4 in London, 4 in South Shields, and 3 in Sheffield. The deaths referred to whooping-cough, which had been 27, 45, and 46 in the three preceding weeks, declined to 35 last week; 9 deaths occurred in London, 4 in Liverpool, 3 in Birmingham, and 2 in Tynemouth. The fatal cases of enteric fever, which had been 13, 18, and 18 in the three preceding weeks, were 16 last week, of which 3 were recorded in Manchester, and 2 each in London, Blackburn, Bradford, and Hull.

The number of scarlet fever patients under treatment in the Metropolitan Asylums and the London Fever Hospitals, which had steadily risen from 2112 to 3731 in the ten preceding weeks, had further increased to 3896 on Saturday last; 597 new cases were admitted during the week, against 530, 534, and 619 in the three preceding weeks. These hospitals also contained on Saturday last 1211 cases of diphtheria, 165 of whooping-cough, 83 of enteric fever, and 61 of measles, but not one of small-pox. The 1159 deaths from all causes in London were 31 in excess of the number in the previous week, and corresponded to an annual death-rate of 13·4 per 1000. The deaths referred to diseases of the respiratory system, which had been 178, 207, and 205 in the three preceding weeks, were 206 last week, and were 37 below the number recorded in the corresponding week of last year.

Of the 4738 deaths from all causes in the 96 towns, 155 were attributed to different forms of violence and 321 were the subject of coroners' inquests. The causes of 42, or 0·9 per cent. of the total deaths, were not certified either by a registered medical practitioner or by a coroner after inquest. All the causes of death were duly certified in Leeds, Bristol, West Ham, Bradford, Hull, Newcastle-on-Tyne, Nottingham, and in 66 other smaller towns. Of the 42 uncertified causes of death, 9 were recorded in Birmingham, 8 in Liverpool, and 2 each in Bury, Manchester, Rochdale, and Sheffield.

## HEALTH OF SCOTCH TOWNS.

In the 16 largest Scotch towns with an aggregate population estimated at 2,259,600 persons at the middle of this year, 1041 births and 701 deaths were registered during the week ended Saturday, Nov. 15th. The annual rate of mortality in

these towns, which had been 14·0, 14·7, and 14·0 per 1000 in the three preceding weeks, rose to 16·2 per 1000 in the week under notice. During the first seven weeks of the current quarter the mean annual death-rate in these towns averaged 14·6, against 13·7 per 1000 in the 96 large English towns. Among the several towns the death-rate last week ranged from 7·6 in Motherwell, 10·5 in Kilmarnock, and 11·0 in Clydebank, to 19·3 in Perth, 19·5 in Greenock and in Kirkcaldy, and 21·4 in Ayr.

The 701 deaths from all causes were 93 in excess of the number in the previous week, and included 84 which were referred to the principal epidemic diseases, against 82 and 55 in the two preceding weeks. Of these 84 deaths, 36 resulted from measles, 21 from infantile diarrhœal diseases, 10 from diphtheria, 9 from scarlet fever, 5 from enteric fever, and 3 from whooping-cough, but not one from small-pox. These 84 deaths from the principal epidemic diseases were equal to an annual death-rate of 1·9, against 1·1 per 1000 in the 96 large English towns. The deaths attributed to measles, which had been 12, 17, and 11 in the three preceding weeks, rose to 36 last week; of this number 16 occurred in Glasgow, 8 in Edinburgh, 4 in Paisley, and 4 in Clydebank. The deaths of infants (under 2 years of age) referred to diarrhœa and enteritis, which had been 19, 34, and 19 in the three preceding weeks, slightly rose to 21 last week, and included 12 in Glasgow, 2 in Dundee, and 2 in Leith. The fatal cases of diphtheria numbered 10, against 11 in each of the three preceding weeks, and included 6 in Aberdeen and 2 in Dundee. The deaths attributed to scarlet fever, which had been 11, 14, and 10 in the three preceding weeks, were 9 last week, of which number 3 were recorded in Aberdeen and 2 in Greenock. The 5 deaths referred to enteric fever, of which 2 occurred in Perth, were 2 in excess of the average in the earlier weeks of this quarter, while the 3 fatal cases of whooping-cough were equal to the average number from this cause in the same period.

The deaths referred to diseases of the respiratory system, which had been 92, 99, and 84 in the three preceding weeks, rose to 97 last week; 24 deaths resulted from various forms of violence, against 32 and 29 in the two preceding weeks.

### HEALTH OF IRISH TOWNS.

In the 27 town districts of Ireland with an aggregate population estimated at 1,199,180 persons at the middle of this year, 616 births and 432 deaths were registered during the week ended Saturday, Nov. 15th. The annual rate of mortality in these towns, which had been 17·8, 17·2, and 17·6 per 1000 in the three preceding weeks, further rose to 18·8 per 1000 in the week under notice. During the first seven weeks of the current quarter the mean annual death-rate in these towns averaged 17·5 per 1000; in the 96 large English towns the corresponding rate did not exceed 13·7, while in the 16 Scotch towns it was equal to 14·6 per 1000. The annual death-rate last week was equal to 20·1 in Dublin (against 13·4 in London and 17·3 in Glasgow), 18·3 in Belfast, 21·1 in Cork, 22·9 in Londonderry, 24·4 in Limerick, and 17·1 in Waterford, while in the 21 remaining smaller towns the mean death-rate did not exceed 14·9 per 1000.

The 432 deaths from all causes were 28 in excess of the number in the previous week, and included 41 which were referred to the principal epidemic diseases, against numbers steadily declining from 132 to 34 in the nine preceding weeks. Of these 41 deaths 15 resulted from infantile diarrhœal diseases, 7 from scarlet fever, 7 from diphtheria, 6 from whooping-cough, 3 from enteric fever, and 3 from measles, but not one from small-pox. The mean annual death-rate from these diseases last week was equal to 1·8 per 1000; in the 96 large English towns the corresponding rate did not exceed 1·1, while in the 16 Scotch towns it reached 1·9 per 1000. The deaths of infants (under 2 years of age) attributed to diarrhœa and enteritis, which had steadily decreased from 111 to 16 in the nine preceding weeks, further declined to 15 last week, of which number 8 occurred in Dublin and 3 in Cork. The deaths referred to scarlet fever, which had been 9, 5, and 8 in the three preceding weeks, were 7 last week, and were all registered in Belfast. The 7 fatal cases of diphtheria, comprising 5 in Dublin and 2 in Belfast, were 3 in excess of the average in the earlier weeks of the quarter. The 6 deaths attributed to whooping-cough were also slightly above the average in recent weeks, and comprised 3 in Belfast, 2 in Galway, and 1 in Lisburn. Of the 3 deaths from enteric fever, 2 were registered in Dublin and 1 in Cork. The fatal cases of measles occurred in Dublin, Belfast, and Galway respectively.

The deaths referred to diseases of the respiratory system, which had been 53, 61, and 69 in the three preceding weeks, further rose to 73 in the week under notice. Of the 432 deaths from all causes 125 or 29 per cent., occurred in public institutions, and 7 resulted from various forms of violence. The causes of 20, or 4·6 per cent., of the total deaths were not certified either by a registered medical practitioner or by a coroner after inquest; in the 96 large English towns the proportion of uncertified causes of death did not exceed 0·9 per cent.

# THE SERVICES.

### ROYAL NAVY MEDICAL SERVICE.

THE following appointments have been notified:—Fleet-Surgeon: J. W. W. Stanton to the *Colossus*, on recommissioning. Staff-Surgeons: F. C. B. Gittings to the *Apollo*, on recommissioning, and as Acting Interpreter in German; and F. G. Wilson to the *Colossus*, on recommissioning.

### ROYAL NAVAL VOLUNTEER RESERVE.

The undermentioned has been appointed Surgeon: Donald Aldridge Macpherson (dated Nov. 14th, 1913).

### ARMY MEDICAL SERVICE.

Colonel Tom P. Woodhouse, on completion of four years' service in his rank, is placed on the half-pay list (dated Nov. 17th, 1913).

Lieutenant-Colonel Henry N. Thompson, D.S.O., from the Royal Army Medical Corps, to be Colonel, vice T. P. Woodhouse to half-pay (dated Nov. 17th, 1913).

### ROYAL ARMY MEDICAL CORPS.

Major Francis W. Begbie to be Lieutenant-Colonel, vice H. N. Thompson, D.S.O., promoted (dated Nov. 17th, 1913).

Colonel G. D. Hunter, D.S.O., has been appointed Assistant Director of Medical Services to the Allahabad and Fyzabad Brigades of the Eighth (Lucknow) Division of the Northern Army.

Lieutenant-Colonel H. N. Thompson, D.S.O., has been selected for appointment as Deputy Director of Medical Services to the Scottish Command. Lieutenant-Colonel C. W. R. Healey has been appointed to the London District for a tour of duty. Lieutenant-Colonel H. M. Adamson has been placed under orders for India and will be appointed to the Sixth (Poona) Division of the Southern Army. Lieutenant-Colonel O. R. A. Julian, C.M.G., has taken up duty at the Royal Hospital, Chelsea.

Major F. M. Mangin has been selected for appointment as Specialist in Ophthalmology to the Poona Division of the Southern Army in India. Major P. S. O'Reilly has been appointed to the Eastern Command for duty. Major G. S. Mansfield has taken over charge of the Military Hospital at St. Peters, Jersey. Major C. C. Cumming has embarked for Malta. Major St. J. B. Killery has been granted six months' general leave of absence home from India. Major T. C. MacKenzie, D.S.O., has taken up duty as Deputy Assistant Director of Medical Services to the Northumbrian Division. Major H. Herrick has been transferred to the Home Establishment from India. Major E. M. Williams has been selected to hold charge of the Military Hospital at Leicester. Major N. H. Ross has embarked for India, and will be appointed to the Lucknow Division of the Northern Army. Major F. S. Walker has taken over charge of the Military Hospital at Fort Camden, Queenstown. Major W. P. Gwynn has been appointed to the Irish Command on return home from Shwebo. Major H. E. M. Douglas, V.C., D.S.O., has taken up duty with the Egyptian Army.

Captain F. W. W. Dawson has been transferred from the Military Hospital at Kasauli Cantonment to Jullundur. Captain R. G. H. Tate, Captain E. D. Caddell, and Captain T. H. Scott have been appointed for duty on board the transport s.s. *Rohilla*, which left Karachi on Nov. 19th. Captain J. C. C. Carmichael has been appointed to the Military Hospital at Khanspur. Captain W. J. Tobin has been granted six months' general leave of absence home from India. Captain A. H. Hayes has been placed under orders for a tour of service with the Third (Lahore) Division of the Northern Army in India. Captain T. E. Harty has embarked for a tour of duty in the Sierra Leone Protectorate. An exchange has been approved between Captain J. B. Meldon, who will proceed to Gibraltar, and Captain T. H. Dickson, who will go to India. Captain B. G. Patch takes up duty at Nottingham. Captain F. M. M. Ommanney has joined at Armagh. Captain A. T. Frost has been appointed for a tour of duty with the Lucknow Division of the Northern Army in India. Captain R. J. Cahill has been appointed to the Military Hospital at Belfast. Captain J. A. Anderson has taken up duty as Company Officer to No. 13 Company of the Royal Army Medical Corps at Edinburgh. Captain J. A. Bennett has been granted leave of absence on medical certificate. Captain W. P. MacArthur has taken up duty as Specialist Sanitary Officer in Mauritius. Captain P. S. Stewart has joined the Military Hospital at Malta. Captain M. Keane has been placed under orders for a tour of duty in India. Captain C. J. A. Balck has taken up duty as a Specialist in Physical Training at Dublin. Captain C. R. Millar has been granted leave of absence home from the Sierra Leone Protectorate. Captain W. A. Spong has been appointed to hold charge of the Military Families and Followers Hospitals at Karachi Cantonment. Captain H. Stewart has taken over charge of the Military Hospital at Halifax. Captain F. H. Bradley has been appointed Specialist in Operative Surgery to the

Lucknow Division. Captain C. G. Sherlock has been appointed to hold charge of the Cantonment General Hospital at Dalhousie. Captain C. J. Wyatt has taken up duty at Port Lokkoh, Sierra Leone Protectorate. Captain A. Dawson has been transferred from Wicklow to the Military Hospital at the Curragh.

Lieutenant B. H. H. Spence has been placed under orders for a tour of service in India. Lieutenant A. L. Urquhart has been appointed for duty to the Queen Alexandra Military Hospital. Lieutenant R. G. Shaw has been appointed to the Dublin District. Lieutenant H. R. L. L'Estrange has joined at Newbridge. Lieutenant C. M. Ingoldby has been appointed to the Military Hospital at Fermoy. Lieutenant F. C. Davidson has been appointed to the Scottish Command. Lieutenant W. O. W. Ball has taken up duty at the Military Hospital, Aldershot. Lieutenant A. G. Brown has joined the Irish Command. Lieutenant B. Biggar has been transferred from the Military Hospital at Cairo to Alexandria. Lieutenant J. F. O'Connoll has been appointed to the Military Hospital at Aldershot. Lieutenant J. M. Elliott has been transferred from the Military Hospital at Hilsea to Winchester. Lieutenant C. V. Thorndon has been appointed to the Irish Command. Lieutenant E. C. Deane has been appointed to the Military Hospital at Chester. Lieutenant R. T. Vivian has taken up duty in the Military Hospital at the Curragh Camp.

### Indian Medical Service.

Lieutenant-Colonel J. Crimmin, V.C., C.B., C.I.E., Presidency Surgeon, Second District, Bombay, has arrived home on leave of absence from India. Lieutenant-Colonel T. Jackson has been selected for appointment as Surgeon Superintendent of St. George's Hospital, Bombay. Lieutenant-Colonel W. H. Ogilvie, medical officer of health and civil surgeon of the notified area at Delhi, has been granted six months' combined leave of absence home from India.

Major J. Williams has been selected for appointment as Civil Surgeon at Dera Ismail Khan. Major W. E. McKechnie has been transferred to Etawah on completion of special duty. Major A. W. Overbeck-Wright, superintendent of the Lunatic Asylum at Agra, has been appointed to officiate as Superintendent of the District Jail at Agra. Major J. H. Husband has taken up duty as Civil Surgeon to the Wano Agency. Major A. C. MacGilchrist has been placed on special duty under the Director-General, Indian Medical Service. Major C. A. Lane, officiating civil surgeon at Darjeeling, has been appointed to act as a Civil Surgeon of the First-class during the absence of Lieutenant-Colonel R. H. Hall. Major H. de V. Condin has been selected for appointment as Civil Surgeon at Hazara. Major E. C. MacLeod has been appointed to officiate as Inspector-General of Civil Hospitals and Prisons and Sanitary Commissioner in Assam during the absence of Lieutenant-Colonel H. E. Banatvala. Major J. N. Walker, civil surgeon at Aligarh, has been granted combined leave of absence home from India for one year.

Captain M. D. A. Kureishi has been appointed to officiate as civil Surgeon at Aden during the absence on leave of Major A. F. W. King. The services of Captain R. A. Needham, medical officer of health at Simla, have been placed at the disposal of the Sanitary Department of the Government of India in connexion with the All India Sanitary Conference to be held at Lucknow next January. Captain A. F. Babonau has been transferred to Ambala as Plague Medical Officer. Captain P. M. Rennie has been appointed to officiate as Medical Officer of Health and Civil Surgeon to the notified area at Delhi. The services of Captain G. Holroyd, officiating superintendent of the Bhagalpur Central Jail, have been replaced at the disposal of the Government of India in the Home Department. Captain N. S. Simpson has been appointed to hold charge of the plague operations at Lucknow on transfer from Kasauli. Captain J. H. Taylor has been appointed to officiate as Assistant Director of the Bombay Bacteriological Laboratory during the absence on leave of Captain W. D. H. Stevenson. Captain R. H. Lee has returned to India on completion of leave of absence. The services of Captain H. C. Brown have been replaced at the disposal of the Education Department of the Government of India. Captain W. E. Brierley has been selected for appointment as Specialist in Operative Surgery.

### Special Reserve of Officers.

*Royal Army Medical Corps.*

Lieutenant Morton W. Ruthven to be Captain (dated Oct. 31st, 1913).

### Territorial Force Reserve.

*Royal Army Medical Corps.*

Major William Owen Evans, from the Unattached List for the Territorial Force, to be Major (dated Oct. 11th, 1913).

6th London Field Ambulance, Royal Army Medical Corps: Lieutenant Walter B. Parsons resigns his commission (dated Nov. 19th, 1913).

1st North Midland Field Ambulance, Royal Army Medical Corps: Captain Edwin A. Wraith to be Major (dated Nov. 19th, 1913).

*Attached to Units other than Medical Units.*—Lieutenant Lionel H. Moiser to be Captain (dated Sept. 11th, 1913).

*Unattached List.*—Major Joseph McGregor Robertson ceases to hold a commission in the Territorial Force (dated Nov. 19th, 1913).

### The Indian Ambulance Gazette.

The October issue of this gazette, which is the official organ of the Indian branch of the St. John Ambulance Association, has just reached us. It contains much matter of interest to ambulance workers in all parts of the Empire, and in addition to association news there are articles on sanitation, malaria, and mosquitoes, the dangers of the house-fly, and an interesting note on the resuscitation of the apparently drowned, the first recorded cases of which appear to have been made in "Derham's Physico-Theology" as having occurred at Troningholm and Oxford about the year 1650. The illustrations include groups of ambulance workers and pictures of the St. John Ambulance Association Headquarters at Malta and of the British Ophthalmic Hospital at Jerusalem. The *Indian Ambulance Gazette* is published at Jutogh, Simla, India, price 6 annas, post free.

### First Aid in the Royal Navy.[1]

Under this title a little book has just been officially issued, and both the service and the author are to be congratulated, the first mentioned in possessing such an excellent and cheap manual, and the second on the terse, clear, and practical manner in which he has treated the subject. In the introduction it is stated that "Everyone in the Navy, especially the officers, must know enough 'First Aid' to be able to help themselves and others in case of need. The object of first aid is not to teach surgery, but to teach purely temporary measures to save life or relieve pain till the doctor comes. First aid should always be very simple in methods and in wording, so that anybody can understand. It is, therefore, not always absolutely scientifically the best treatment, but is rough and ready, and the best under the circumstances." We quote the above admirable definition and explanation because they indicate exactly how the author, who certainly knows how to teach, has written his book. First aid at sea necessarily differs in some respects from first aid on land by reason of the difference in environment and the presence or absence of makeshift appliances due to that environment, as well to the nature of the accidents likely to happen. This is clearly shown in the text and in the many illustrations with which the book abounds. The anatomical and physiological illustrations and diagrams, some of them coloured, are exactly suited to the purpose of elementary instruction.

The King has granted Captain J. Powell, R.A.M.C., permission to accept and to wear the Imperial Order of the Osmanieh (Fourth Class) conferred on him by the Khedive of Egypt in recognition of valuable services rendered.

[1] First Aid in the Royal Navy. London: H.M. Stationery Office, Messrs. Wyman and Sons. Messrs. Eyre and Spottiswoode, Messrs. Fisher Unwin; Edinburgh: E. Ponsonby; and agents abroad. Pp. 190. Price 9d.

**Medico-Legal Society.**—The next meeting of this society will be held at 11, Chandos-street, Cavendish-square, London, W., on Tuesday next, Nov. 25th, at 8.30 P.M., when a paper on the Urgent Necessity for the Treatment of Early or Threatening Insanity, and the Need for Immediate Legislation, will be read by Dr. Robert Jones. Members willing to exhibit medico-legal specimens or contribute papers, &c., to the Proceedings of this session should communicate with the honorary secretaries, Mr. J. Howell Evans, 25, Berkeley-square, W., and Mr. G. W. Cooper King, 9, Gray's Inn-square, W.C.

**Scarlet Fever in London.**—London is suffering from a severe epidemic of scarlet fever, and the Metropolitan Asylums Board are finding some difficulty in immediately removing to their hospitals every notified case. There are plenty of vacant beds, but the supply of nurses of the lower grades is difficult to maintain and at present totally inadequate to meet the demands made upon the Board. To some extent the situation is being dealt with by engaging institutional nurses, and steps are being taken to make the conditions under which the nursing staff serve more attractive. At a meeting of the managers of the Board held on Nov. 15th it was reported that all the notified cases had been taken in, save one at Tottenham. It was also reported that during the fortnight ending Nov. 8th 3699 scarlet fever patients were under treatment compared with 3438 for the preceding fortnight. These figures show an increase of more than 1000 cases when comparison is made with the corresponding weeks of 1911 and 1912.

# MEDICAL PRACTICE UNDER THE INSURANCE ACT.

(BY OUR SPECIAL COMMISSIONER.)

(*Continued from p. 1348.*)

## XXVII.—DERBY, DERBYSHIRE, AND COUNTY PRACTICE.

No fight was set up at Derby or in the county of Derbyshire against the Insurance Act. The Derbyshire practitioners were quite ready to work the Act and held no indignation meetings. They did, of course, object to the offer of 4*s.* 6*d.*, but not to that of 7*s.* Then they also objected, and still object, to the lay control that can be exercised by the Committees, but nevertheless they determined to give the Act a 12 months' trial, and on its side the Derby Insurance Committee acted from the first very discreetly. It avoided interfering with the members of the profession, so that the work has proceeded smoothly, and it left all medical matters that needed some sort of professional action to the Local Medical Committee. Thus I found that the practitioners had nothing to say against the local authorities and were mainly concerned with the suggestions received from time to time from the Commissioners. The interference of the latter has not always been welcome, and there is undoubtedly in both the town and county of Derby a disposition to resist some of the proposals coming from them.

But while in a general way most of the practitioners appear satisfied with the Act, yet it is also recognised that objections still exist. Thus it is thought that a small charge should be made for unnecessary calls, especially night calls. This was the amendment most frequently mentioned to me within the city of Derby as immediately desirable. During the first nine months of the working of the Act the Medical Service Subcommittee (the Committee of Complaints) has never been called upon to meet. Therefore no serious complaints have been received.

### *Mileage and County Practice.*

Much of what has been said of the city of Derby applies also to the county of Derbyshire. Of its 560,129 inhabitants 178,294 are insured under the Act. These figures do not comprise the borough of Derby. As in the town so in the county nearly all the practitioners, to the number of about 300, are on the panel. No contracting out has been allowed; while there are not many panel doctors who have too many insured persons on their list. One practitioner who has neither partner nor assistant has, I was informed, some 3000 insured persons on his list and also clubs for uninsured women and children. He seems to have rendered himself responsible for the medical needs of over 700 families, and to do this he has to work far more than is good for any man—and this in normal times. What will happen to him in the event of an epidemic it is difficult to say.

The payments for all contract work in the county have been effected regularly, every quarter for the panel doctors and every month for the pharmaceutical chemists. Those panel doctors who dispense medicine because their patients live more than a mile away have been paid the full 9*s.*, and no difficulty has arisen on this score. But the allowance for mileage, which the panel doctors themselves should receive when they attend to the sick in sparsely populated parts of the county, has not yet been settled. There are moorland cottages in the Norton, Buxton, and other districts that are far apart and very inaccessible. As yet no mileage payments have been made to anyone in the county, and it is high time this question should be taken in hand and settled.

### *The Pharmaceutical Chemists in Town and Country.*

The position of the panel pharmaceutical chemists or druggists varies, like that of the panel doctors, with different localities. It depends mainly on local conditions. Though the payment is the same, the advantages derived from the working of the Act are very dissimilar. Thus in towns the druggist incurs a greater outlay in rates, taxes, and rent. If he has to devote too much of his time to making up the prescriptions for panel patients he cannot regard the work as remunerative. As an extra, something to do in the less busy hours of the day, the work is very welcome. But he has a strong objection to see his shop crowded with insured persons bringing their prescriptions during the hour when his more profitable customers are shopping. He wants to attend first to that which pays best, and is in no wise pleased that insured persons should interfere with his ordinary business. To the urban pharmaceutical chemist the National Insurance Act has not been wholly acceptable even where full payment has been received. To the rural chemist the Insurance Act is a great advantage. He need not fear to see his shop overcrowded by insured persons, and he gets the same pay for the drugs he sells, though his rent and taxes are much less than those of his town brother. Then in many villages there is but one medical practitioner, and the chemist either is, or soon becomes, familiar with his style and range of prescribing, and this to such an extent that he can have some of his favourite prescriptions prepared in advance, to the great saving of the time of both himself and the patient.

The small rural places are frequently the most difficult to deal with when planning any national scheme. For instance, if in the application of the Insurance Act the Government did its own dispensing it would lose the valuable and economical help of the country chemist. For this reason no such scheme received any consideration during the discussion on the measure. The urban chemist, on his side, finds that in some places coöperation with the Insurance Act injures his business—that is, the proportion of insured persons to the population can become too high.

The Act is doing away with the prescribing chemist, and this fact the best pharmaceutical chemists unite with the medical profession in welcoming. The custom of going to the chemist for advice as well as for a bottle of medicine is dying out rapidly, for the public argues, Why consult a chemist when it does not cost any more to go to a panel doctor? Formerly the fact that many chemists openly prescribed was a legitimate grievance to the medical profession, and many proposals were brought forward to check this practice. To-day there is a risk lest some practitioners on the panel should actually wish their patients to continue consulting dispensing chemists for small ailments—an unprofessional point of view which it is hoped will find no support from any of the other people concerned.

### *Growing Influence of the Insurance Companies.*

In the county of Derby there are 456 Approved Societies, and the administration of benefits takes place in three ways. First, there is the Post Office

system, with only some 200 members, about which I have heard no particular complaints. Then we have the amalgamation of Friendly Societies at Chesterfield and a similar institution at Derby, already described. The two latter have given rise to many comments, and there is a good reason for the attitude adopted and shared by the dispensing chemists with the panel doctors. The chemists say that if, on the one hand, they lose many private customers who used to buy drugs at the full price and who now come with a panel doctor's prescription, they ought to benefit by the increased number of small but regular payments accruing from the insured. But, as a matter of fact, many thousands of these insured persons do not bring their prescriptions to the dispensing chemists, but get their medicine from institutions for whom, of course, duly qualified dispensing chemists are working. As these institutions are allowed to do their own dispensing they can compete, and in such places as Chesterfield compete very successfully, against the chemists. At Derby the number of members of the Amalgamated Friendly Societies' Medical Aid Association, as it is called, amounts to about 4000 persons, of whom half are insured under the Act. This is a large number of patients for the chemist, as also for the panel doctors, to lose, and is not in accord with one principle of the Act—namely, free choice of doctor; but it does not represent anything like the same proportion of the population as is the case in regard to the membership of the Chesterfield District Medical Association. The old clubs and Friendly Societies, not forming part of these amalgamations which have succeeded in obtaining recognition as institutions providing medical attendance before the Act, have now quite abandoned the medical side of their work. This has been advantageous to the profession, as all the members of such bodies now place their names on the lists of the panel doctors. Some of these Friendly Societies have been slow to move, while the commercial insurance companies sent out innumerable well-trained canvassers. These men quickly obtained the names of persons who had never been insured, gave them promptly the required explanations, and persuaded them to carry out their part of the duties imposed by the Insurance Act through the agency of the commercial companies. In this manner they captured half the county of Derby, and throughout the United Kingdom the same sort of thing has been going on to varying extents. Mr. Sidney Webb, early in the discussions on the measure for National Insurance, estimated that the Trades Unions and Friendly Societies had not enrolled more than 1,750,000 of previously uninsured persons. There remained over 4,000,000 men and 3,250,000 women. The 50,000 agents of the great industrial insurance companies probably enrolled four-fifths of the previously uninsured persons in the kingdom. The management of the Act was to have been based on the democratic principle of the election by insured persons of their representatives to the Insurance Committees. Instead of this we have members of great profit-making companies who are more likely to follow the instructions of their board of directors than the inarticulate desires of the insured persons they are supposed to represent. This growing influence of commercial companies has to be watched by the medical profession, lest the medical men, without whom the Act is a dead letter, should allow all the advantages of the measure to escape them.

*Incompetent Inspection for Malingering.*

In the county of Derby at the end of the first quarter of this year there were some 20,000 insured persons who had not yet chosen their panel doctor. Since that time about half have made up their minds, so there now remain only some 10,000 without a medical adviser. No use as yet has been made of the money these people have paid. It is now proposed to allocate them according to the amount of work the panel doctors do; but, as a matter of fact, with this as in regard to malingering, there is a general tendency to wait and see what advice the Insurance Commissioners will give. The delay, especially in regard to the latter question, may be considerably more than six months. In the meanwhile the Medical Committee of the county of Derby have consulted with the Approved Societies over their proposals and have agreed in principle that it might be advisable to form a panel of referees, such referees to be paid for each case referred to them a fee of half a guinea if the patient suspected of malingering attended at the surgery and a guinea if the referee had to go to the patient's house.

There is some trouble with the Friendly Societies and the insurance companies in regard to medical certificates and malingering. Thus, let us say, a patient presents himself with a high temperature and a headache. There are 20 or more patients waiting. In the inevitable crowding of contract practice (which we all hope to see decline as the participators achieve order through experience), finding it impossible to make a proper diagnosis, the practitioner sends the patient to bed and puts "headache" on the certificate. Thereupon the Friendly Society to which this patient belongs, not recognising a headache as a serious complaint, accuses the man of malingering, yet this was no fault of his own, he was only waiting till the practitioner could find time to make a proper diagnosis; and the practitioner, sincerely desirous of regarding a proper diagnosis as his first duty to the preventive medicine of the country, cannot invent a day of more than 24 hours. Then all kinds of silly mistakes arise because the Friendly Societies send out inspectors to detect cases of malingering, though these persons have no technical knowledge whatsoever. If they discover a patient lifting a kettle off the fire they suspect he is not so ill as he pretends to be. They thus enforce idleness on those who are recovering, whereas a little movement and exercise would in many cases be beneficial. To come upon a patient taking a short walk or merely standing on his own doorstep has resulted sometimes in a report being drawn up and the matter being investigated in all its details as probably one of malingering. The panel doctor then receives complaint, or at least a letter of inquiry, and he is put to the trouble of having to write and explain that he did order the patient to take a little exercise.

*Altered Conditions of Practice in Mining Districts.*

The Act is sometimes considered to have failed because, in not a few cases, better payment has not insured better treatment. Thus formerly where only 4*s.* to 5*s.* a year was paid for medical aid and medicine the sum now allowed for insured persons may be as much as 9*s.* It was thought that this would attract more medical men to working-class districts. The old-established local practitioners were not to enjoy any notable increase of income. They would not lose, it was supposed, by earning as much as formerly while having fewer patients. The

newcomers would be supported by the rest of the new funds. In this manner, and without a loss of income to anyone, much more time could be devoted to each individual case. The interests of science would greatly gain, the effectiveness of the work done and the dignity of the profession were bound to benefit from such a change. The fallacy, of course, was in the assumption that medical men were satisfied with the total incomes that they were able to make and in the supposition that the possibility of making similar incomes would prove attractive. Among the miners of Derbyshire no new medical men came, but the Act led to much more work. Some professional incomes have increased, but the time to do good work has not increased, rather it has decreased. Too gloomy a view of all this must not be taken, as improvement is bound to occur as the working of the Act becomes more familiar alike to practitioner and patient. In the mining villages already a considerable improvement has taken place in one respect. The managers of some of the collieries were not infrequently looked upon as small tyrants. It was not only the workmen who trembled, but the colliery surgeon was also expected to be subservient to the local autocrat. Now, however, the colliery surgeon is no longer employed by the colliery manager. His name is on the panel, and he is in nowise beholden to the former chief of the village.

Taking it all in all, the Act is working well in the county of Derby. There is some grumbling, and a very serious grievance against the two great medical aid institutions that are allowed to employ whole-time medical officers and do their own dispensing, but otherwise more satisfaction than dissatisfaction is expressed.

*(To be continued.)*

CENTRAL MIDWIVES BOARD.—Special meetings of the Central Midwives Board were held on Nov. 11th and 12th at Caxton House, Westminster, with Sir Francis H. Champneys in the chair. A number of midwives were struck off the roll, the following charges, amongst others, having been brought forward: Neglect to take the temperature of the patient, as required by Rule E. 13; not being scrupulously clean, as required by Rule E. 1; medical aid having been called to a patient, the midwife omitted to send any notification thereof to the local supervising authority, as required by Rule E. 21 (1). A child suffering from inflammation of and discharge from the eyes, the midwife did not explain that the case was one in which the attendance of a registered medical practitioner was required, nor did she hand to the husband or the nearest relative or friend present the form of sending for medical help, properly filled up and signed by her, in order that this might be immediately forwarded to the medical practitioner, as required by Rule E. 20 (5). Not attending to the cleanliness and comfort of the patient, as required by Rule E. 11. Being in contact with a large number of cases of skin disease in the case of newly born children, the midwife made no effort to notify the local supervising authority, nor did she make any attempt to procure disinfection of herself, her clothing, and her appliances, so as to avoid the spread of infection. Not washing and swabbing the patient, as required by Rule E. 7; being unable to make use of a clinical thermometer, and consequently unable to take the temperature of patients, as required by Rule E. 13; not being scrupulously clean in person, clothing, appliances, and house, as required by Rule E. 1; neglect to make use of any antiseptic precautions, as required by Rules E. 3 and 7, and omitting to provide for the comfort and cleanliness of the patient, as required by Rule E. 11. Not wearing a clean dress of washable material, when attending patients, as required by Rule E. 1; not keeping the register of cases as required by Rule E. 23, and administering to a patient a drug other than a simple aperient without recording it in the register, as required by Rule E. 18.

# Home and Foreign Notes.

(FROM OUR OWN CORRESPONDENTS.)

## SHEFFIELD.

### *Lord Haldane on Clinical Teaching.*

IN opening the new buildings of the applied science department Lord Haldane delivered an admirable address on the ideals of a university in a large city. He dealt with various aspects of the subject and illustrated his remarks by many happily chosen examples. Referring to the methods of clinical teaching in this country he compared them with those existing on the continent and elsewhere. Here the practising physician or surgeon teaches his students at the bedside, giving them the value of his personal experience and actually dealing with the cases as they would be dealt with by a practitioner in his own practice. In Germany, on the other hand, the professor in his lecture theatre takes a single case, and having been provided with every information about it, obtained with the help of his numerous assistants, goes completely and fully into that case as a whole and demonstrates it to a large class of students. Lord Haldane declined to express any opinion as to the relative superiority of either method of teaching. He indicated valuable points about each, and suggested that we in England should devise a system of clinical teaching combining what is best in both. With these views medical men in Sheffield, especially those with teaching appointments, all agree, but surely such a combination is more general than Lord Haldane's words would lead one to imagine. The difficulty of the matter is usually the very common one of "Pounds, shillings, and pence." The chairs of medicine and surgery are in most places but ill-paid—if paid at all—and the occupation of them is not lucrative. Moreover, the British hospitals are usually understaffed owing to lack of funds, so that a sufficient number of assistants cannot easily be provided. This is particularly the case at the present time when even with increased salaries it is difficult to obtain resident officers, and still more so to keep them. And it must not be forgotten that whilst the giving of clinical demonstrations to large classes has some obvious advantages, still there is a very real danger that it may tend to supersede practical work in the wards, and that the student may complete his courses without having really come in personal contact with patients at all.

### *The National Insurance Act.*

Sheffield was one of the last strongholds in the North of England to capitulate, and only did so when the Chancellor of the Exchequer brought up his big guns and threatened complete destruction. Nearly a year has gone by and the sounds of dissatisfaction with the Act emanating from the medical profession do not increase in audibility. There is no doubt that those practising in the poorer districts which abound in the city and neighbourhood have never before been in so good a position financially as they are to-day, and that alone tends to check grumbling. Whether the public has gained by the Act or not is another matter. If they have not, the blame cannot be laid upon the medical profession, whose warnings were many and loud, but fell on deaf ears.

*The Faculty of Medicine of the University.*

The University is to be congratulated upon the steady progress which is being made in the Faculty of Medicine. The entry of medical students in October, though numerically small compared with those at the larger schools, is larger than it has been before. This steady increase during the last three years, coupled with the larger percentage of students taking a degree course, is distinctly gratifying at a time when in many places the numbers are decreasing. There has been lately an increasing number of women medical students, to whom the facilities for study offered at all stages of their curriculum are very complete. Probably the numbers will continue to mount, as funds are about to be collected towards a residential women's hostel. Meanwhile, thanks to the generosity of "A Sheffield Citizen," a medical scholarship value £100 will be offered annually to women, beginning next year.

*Post-Graduate Work in Connexion with the University.*

The Faculty of Medicine has made a great point of encouraging post-graduate study. It has realised that this is a part of the duty of a university hardly less important than that of promoting original research or educating students. Last year it gave a special course on Tuberculosis, and a special extension course on Immunity was given at Derby by the professor of pathology. The attendance on both of these was very encouraging. During the present winter a course of clinical demonstrations is being given by members of the University staff twice weekly at the Royal Infirmary and Royal Hospital. An interesting programme has been drawn up, and that it supplies what the practitioner wants is sufficiently indicated by the large number of those taking out the course, a number far in excess of any previous year.

*Medico-Chirurgical Society.*

In consequence of his election as president for the year, Dr. W. S. Kerr has resigned the post of honorary secretary, which he has held for many years. At the opening meeting of the winter session the members took the opportunity to recognise his services by presenting him with a silver tea and coffee service. The presentation was made by Professor D. Burgess and Professor Sinclair White on behalf of the members of the society. Owing to the increasing work of the society it has been arranged that in future there shall be two secretaries—medical and surgical respectively—and that the posts shall be tenable for a limited period only. Included in the programme of the coming session is an address by Sir Arbuthnot Lane on Intestinal Stasis. The Pathological Section held its first meeting of the session on Oct. 30th. A discussion on the Pathology of Cerebro-spinal Fluid was opened by Dr. Herbert G. M. Henry, and several speakers followed. There was a large attendance. This recently formed section of the society has proved an attractive addition to the general work of the society. Amongst the features of its sessional programme is a paper by Dr. F. W. Mott, on Feb. 26th, 1914.

*The Edgar Allen Institute.*

This institute for medico-mechanical therapy, founded on the Zander methods, has now nearly completed three years of useful work. The institution is remarkably complete in its equipment and is managed by a committee representative of the various public bodies in the city, including the Lord Mayor, the Master Cutler, the chairmen of boards of guardians, hospitals, &c., and many others. In order to insure that only suitable cases are received no patient is admitted for treatment except upon the recommendation of a medical man. The articles of association preclude any personal profit being made by the committee. The morning hours at the institution are devoted to patients unable to pay for treatment, whilst paying patients are dealt with in the afternoons. Unfortunately, the percentage of paying patients does not as yet suffice to defray the upkeep of the institute. Thanks, however, to the generosity of the donor, Mr. Edgar Allen, by whom the heavy initial cost of the premises and equipment was defrayed, the large annual adverse balance has hitherto been met by him personally each year. The institute, however, must begin to be self-supporting, and strong efforts are being made by the committee to attain this object.

Nov. 18th.

## BRISTOL AND WESTERN COUNTIES.

*The University of Bristol: the Court and the "Scandals."*

IN the constitution of the University of Bristol the court, a widely representative body, has the final word in such matters as those referred to it for decision at its recent meeting. For some months past a press campaign has been carried on, anonymously to a large extent, for the vilification of the authorities in regard to various matters. The rather wide distribution of honorary degrees gave, I presume, the first excuse for these attacks, and the charges made against the council in this connexion include all sorts of vague accusations and insinuations. From this mass of innuendoes one definite charge stood out. At the time when University College, Bristol, was merged in the University, about three years ago, Professor Cowl, who had held the chair of English in the College, was not appointed to the corresponding University chair. This, which was no doubt tantamount to a dismissal, was accompanied by the creation of a research professorship with a substantial salary, which Professor Cowl accepted and held for two years. The press onslaught on the University was crystallised into a demand for a public inquiry into the circumstances of this "dismissal." At last week's meeting of the court Professor Turner, of New College, Oxford, brought forward a resolution asking the council to furnish the court with this information. This was done, as Professor Turner explained, in a perfectly friendly spirit, to afford opportunity for a proper official pronouncement on the matter. From the speeches which followed it was made clear that the council was willing to furnish the information if the court desired it. The Vice-Chancellor, Sir Isambard Owen, said that it was impossible to go into details as to the reasons which had guided the council in its decision respecting Professor Cowl; further than this, that nothing had been alleged against him except matters bearing upon his qualifications for the post. He thought the decision had been justified at the time and also by subsequent results. The resolution was lost by an overwhelming majority, only three members voting for it. This closes the door to Professor Cowl's supporters. It is felt here that any claim to a public inquiry which he may have possessed is substantially lessened by his acceptance of the research professorship.

*Bristol General Hospital.*

When Mr. Joseph Storrs Fry's death left the presidentship of the hospital vacant it was generally felt that it would be difficult to find a worthy successor. The hospital is, however, extremely fortunate in having persuaded Mr. George A. Wills, the head of the well-known tobacco firm, to accept the office. The appointment has given the keenest gratification to everyone concerned. Equally fortunate has been the choice of a treasurer; Mr. Herbert M. Baker, who has been elected to the office (which was also held by the late Mr. Fry), has for years been chairman of the committee, and his energy and capacity for organisation have been largely responsible for the material advance which the hospital has made in recent times.

*Scarlet Fever in Bristol.*

Scarlet fever is epidemic in Bristol. Fortunately, it is of a mild type; out of 811 cases notified during the first ten months of the current year only three have ended fatally. It is well that this is the case, for the accommodation in the isolation hospitals is grievously inadequate, a fact which has been insisted upon again and again by the medical officer of health.

*Society of Medical Officers of Health.*

The West of England and South Wales branch of this society dined last week in Bristol at the Royal Hotel. Interesting speeches were made by the Bishop of Hereford, by Mr. Herbert Jones (president of the branch), and others.

*"Sweating" District Medical Officers.*

At a meeting of the St. Thomas's (Exeter) board of guardians on Nov. 14th the Rev. Dr. Browne, in supporting the application of Mr. Charles E. Gaitskell for an increase of salary, said that Mr. Gaitskell received a salary of £12 per annum as medical officer for Lympstone district (population 1000) and had to supply the medicine, and described the condition of affairs as "sweating." The subject was referred to the visiting committee.

*Death of Mr. James Somer.*

Mr. James Somer, M.R.C.S., L.S.A., died recently at his residence, "Uplands," Exeter. He was born in Cornwall, and educated at the Launceston Grammar School. After being apprenticed to the North Devon Infirmary, Barnstaple, he proceeded to University College Hospital, London, taking the double diplomas in 1858. He practised for a short time at Boscastle, Cornwall, and was presented with a handsome clock on his departure. He then removed to Broadclyst, Devon, where he made a large connexion. He was medical officer and public vaccinator for his district. For several years he was a manager of the Broadclyst Schools and a trustee of the local charities. About 12 years ago he retired from active work and took up his residence at Exeter.

*A Proposed Hospital for Okehampton.*

It is proposed to erect a cottage hospital at Okehampton, for which General Holley has given the site. The Holditch trustees have £1000 in hand, enough to defray the estimated cost of the building. The local nursing association has £150 to be utilised for furnishing the institution. The maintenance of the hospital is estimated at about £200 per annum, which amount could be defrayed by the Holditch Trust and the nursing association conjointly. Plans have been prepared, and it is hoped that the proposal will be carried through.

Nov. 18th.

## SCOTLAND.

*Medical Opposition to the National Insurance Act in Scotland.*

AT a meeting of the Medical Guild held in Edinburgh on Nov. 15th, and attended by more than 100 medical practitioners, Dr. John Playfair presiding, the following resolution, moved by Professor William Russell, was carried:—

**That this Guild adheres to the position it adopted when the National Insurance Act came into operation, and it resolves to federate with all associations which hold a similar policy—namely, the maintenance of the honour and freedom of the medical profession and the continuance of an uncompromising opposition to the method of administration of the medical benefits under the Act.**

*Edinburgh Medico-Chirurgical Society.*

The following office-bearers have been appointed for session 1913–14:—President: Dr. John Playfair. Vice-Presidents: Dr. G. H. Melville Dunlop, Professor William Russell, and Mr. J. W. B. Hodsdon. Councillors: Dr. H. A. Leebody, Dr. H. G. Langwill, Dr. John Eason, Mr. Alexander Miles, Mr. J. M. Cotterill, Dr. E. F. Armour, Dr. James Wilson, and Dr. J. S. Fowler. Treasurer: Dr. H. Torrance Thomson. Secretaries: Mr. A. A. Scot Skirving and Dr. Edwin Bramwell. Editor of Transactions: Dr. D. Chalmers Watson.

*Glasgow Maternity Hospital.*

For some time it has been known that the finances of the Glasgow Maternity Hospital have not been in a satisfactory condition. The hospital was founded 80 years ago, and during that time it has been of immense benefit to mothers of the poorer classes and to nurses and medical students seeking a training in midwifery. The work was so hampered by the inadequate accommodation of the hospital that ten years ago the directors decided to erect a new hospital near the same site, retaining the old building to form gynæcological wards. Six years ago the new building was completed, and it forms one of the finest hospitals of its kind in Britain. Unfortunately, for some reason or other the maternity hospital does not benefit from legacies in the same way as other hospitals in the city, and the result is that it has no capital account. The building fund is still nearly £10,000 short, and, what is far worse, the annual income has been for the last few years £3000 short, so that the accumulated shortage for the last few years amounts to £11,000. To clear this off a bazaar was held last week and the opening ceremony was performed by Princess Louise. The total results of the bazaar were £17,003, and it was announced that in addition an anonymous donor had promised the sum of £3000 towards the development of clinical and pathological research in the hospital.

*Aberdeen Maternity Hospital.*

Since the passing of the National Insurance Act the Aberdeen Maternity Hospital has experienced a reduction in the number of cases. One reason for this, it is supposed, is that medical practitioners are now willing to take on cases which they would not previously have done, being in some measure assured of payment. These cases would formerly have gone to the hospital.

*Diphtheria in Aberdeen.*

The epidemic of diphtheria from which Aberdeen has been suffering for some weeks has only partially abated. From 59 cases notified the week before, the number rose to 70 last week. Fortunately the disease continues, for the most part, to be mild.

In the suburbs and on Lower Deeside attacks are being notified, and the Banchory Higher Grade School has been closed on account of it.

*Aberdeen Royal Infirmary and Town Council.*

A point of considerable interest has emerged in connexion with the electric current of the Aberdeen Royal Infirmary and the Aberdeen town council. Requiring electric power for new laundry plant, the infirmary applied for the current to the Aberdeen town council. This, it is understood, has been categorically refused, and the municipal authorities who are concerned with the matter are stated to have imposed conditions which practically render it impossible for the infirmary to obtain from the corporation electricity department the required power. As a matter of economy, in the days before the corporation electric lighting was developed as it now is, the directors of the Royal Infirmary put a valuable electric lighting plant into the institution, thus utilising in some measure the large furnaces needed otherwise for heating, &c., to provide steam for driving the electric lighting plant. Now, it is understood, when the infirmary requires more power than can be generated by the private plant for laundry purposes, the authorities have refused to give it unless under the conditions that lighting current for the institution be also taken from them, thus rendering useless the valuable and useful plant at present supplying the infirmary with light. The attitude of the authorities towards an institution existing so much for the public good as the Royal Infirmary does requires explanation.

Nov. 18th.

## IRELAND.

*Dental Clinics in National Schools.*

AT a meeting of the Council of the Women's National Health Association held in Dublin last week an interesting statement was made by Mr. Lemass, secretary of the Board of National Education, with reference to the attempt by the Board to establish dental clinics in the primary schools in Ireland. In 1911 the Board asked the Treasury for £13,530 to cover the cost of four dental clinics in Dublin, four in Belfast, three in Cork, two in Limerick, two in Derry, and one in each other town of over 9000 inhabitants. In reply the Treasury offered £7500 on condition that an equal sum should be contributed from local sources. After conference with the school managers the Board pointed out to the Treasury that local authorities in Ireland had no statutory power to strike a rate for such a purpose. Further, the Board asked permission to spend the £7500 promised by the Treasury in establishing as a tentative measure dental clinics in a few of the larger towns. The Treasury refused to sanction any expenditure except on the principle of equal contributions from local sources. As a result, only £263 2*s.* 6*d.* was given by the Treasury, an equivalent sum being raised voluntarily in certain localities. For the present financial year an expenditure from the vote of £953 6*s.* 3*d.* has been sanctioned. This is divided among 32 schemes. Over one-third of this money is in aid of schemes promoted by the Women's National Health Association.

*The National University of Ireland: A Proposed Degree in Ophthalmology.*

At the meeting of Convocation of the National University of Ireland last week a resolution was carried, urging the Senate to establish a degree or diploma in ophthalmology. It is not expected that the Senate will take any action in the matter. If degrees in ophthalmology are established, there seems to be no reason why the medical specialties, such as otology and laryngology, should not be similarly recognised. It was resolved at the same meeting of Convocation to request the Senate to institute lectures for medical practitioners, in order to train them for the work of medical inspection of schools.

*Scarlet Fever in Belfast.*

Owing to the prevalence of scarlet fever in Belfast it has been decided to give the medical officer of health extra assistance in coping with the epidemic, and also to have a conference with the various medical officers of health (dispensary doctors of the Belfast district) on the question of the outbreak, which is gradually increasing both in extent and in virulence. At present over 500 cases are in the two fever hospitals (municipal and workhouse), a number never equalled before, and the severe septic type of case is also increasing.

*Munificent Gift to Belfast University.*

Mr. William Gibson, an Ulsterman, who died on Nov. 1st, has left a legacy of £10,000, free of duty, for the purpose of founding certain scholarships to be called the "Gibson Scholarships," in the Queen's University of Belfast.

*The Stamping of Meat in Belfast.*

The chairman of the markets committee of the Belfast city council, Dr. Henry O'Neill, has been negotiating in order to get the various Belfast institutions concerned to arrange that for the future all meat purchased by contract for their inmates shall bear the official stamp, as a guarantee that it has been examined by a duly qualified inspector and certified as being good for food. There is no legal power to make this stamping obligatory on butchers, but if in the time to come this is made a condition of contract purchase the official stamping will soon become general. Dr. O'Neill, who deserves high credit for his efforts, has now persuaded the following institutions, representing several thousand inmates, to agree that in the future all meat supplied to them shall be branded with the Belfast Corporation abattoir stamp: The Belfast Union Workhouse, Belfast Lunatic Asylum, Royal Victoria Hospital, Throne Convalescent Hospital, Belfast Prison, Belfast Charitable Society, and Purdysburn Fever Hospital.

*The Ulster Medical Society.*

The annual dinner of the Ulster Medical Society was held in the Medical Institute, Belfast, on the evening of Nov. 6th, Dr. A. B. Mitchell, the President, occupying the chair. After the loyal toasts had been drunk, Sir William Whitla handed over to the Medical Institute, on behalf of the subscribers, a picture of the late Dr. Joseph Nelson, which was unveiled by Dr. J. W. Browne, who gave a feeling account of his old friend. Professor J. A. Lindsay proposed the toast of "Irish Medicine," to which Dr. C. E. Fitzgerald, President of the Royal College of Physicians of Ireland, and Dr. R. D. Purefoy, President of the Royal College of Surgeons in Ireland, responded. Dr. Browne having been handed a certificate of election as an Honorary Fellow of the Society, Mr. R. J. Johnstone proposed "The Guests," to which the Recorder of Belfast and Mr. G. R. Lawless replied. The President's health and that of the honorary secretary, Dr. S. T. Irwin were acclaimed in conclusion.

Nov. 18th.

# Obituary.

## CHARLES McBURNEY, M.D.,

LATE PROFESSOR OF CLINICAL SURGERY, COLUMBIA UNIVERSITY, NEW YORK.

By the death of Dr. Charles McBurney, which has taken place in Brookline, Massachusetts, the medical profession of America loses one of its most eminent surgeons.

Dr. McBurney was born in 1845. He received his professional education at the New York College of Physicians and Surgeons, now the medical department of Columbia University, where he took his M.D. degree in 1870. He subsequently studied in London and on the Continent at Vienna, Berlin, and Paris. In 1892 he became professor of clinical surgery at Columbia University, retiring from the post in 1907, when he became emeritus professor. He was an admirable teacher. He was not a voluminous writer, but he made many communications to medical societies in the United States and in Europe, and his name is inseparably linked with the subject of appendicitis, for it was he who in a paper before the New York Surgical Society in November, 1889, defined the diagnostic feature in the early stage of appendicitis of localised tenderness on pressure at a point about 2 inches from the anterior superior spine of the ilium on a line from that process to the umbilicus, now universally known as McBurney's point. McBurney's incision, parallel with the course of the external oblique muscle about an inch from the anterior superior spine, also links his name with that disease.

Dr. McBurney was visiting surgeon to St. Luke's Hospital, New York, and was also on the surgical staff of the Bellevue, Presbyterian, St. Mark's, and Roosevelt Hospitals. Among his foreign professional affiliations he was an Honorary Fellow of the Royal College of Surgeons of Edinburgh. The Surgical Society of Paris, the Medical Society of Rome, the Medical and Surgical Society of Constantinople all claimed him as a member. His principal contributions to medical literature, other than those relating to appendicitis, were the article on the Technique of Aseptic Surgery in the International Text-book of Surgery (1899) and a paper, in conjunction with Dr. Allen Starr, of New York, on the Diagnosis, Localisation, and Operation for the Removal of three Tumours of the Brain, which was published in the *American Journal of the Medical Sciences* in 1893. When President McKinley was assassinated in September, 1901, Dr. McBurney was sent for to attend him.

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DONATIONS AND BEQUESTS.—The Chelsea Hospital for Women has received from the executors of the late Mrs. Snelgrove, in virtue of their discretionary power, a bequest of £100, also £10 10*s.* from the Skinners' Company.—Mrs. Formby has given £1000 towards the funds of the Monmouthshire Hospital, and the committee has also received £500 bequeathed by the late Rev. R. H. Jackson, who recently died at Clifton.—The late Mr. John Anderson bequeathed £2000 each to the Middlesex Hospital and the New Hospital for Women.—The Royal Lancaster Infirmary has received £500 under the will of the late Mr. Edward Storey.—Subject to two life interests, the late Mr. Edward Farey has left £2000 to University College Hospital.—The late Mr. William Gibson has bequeathed £10,000 to Queen's University, Belfast.—The Merchant Taylors' Company have sent £500 to St. Bartholomew's Hospital, being the first moiety of a grant of £1000.

# Correspondence.

"Audi alteram partem.

## THE ACCURACY OF CLINICAL THERMOMETERS.

*To the Editor of* THE LANCET.

SIR,—Your comment on my letter in THE LANCET of Nov. 15th shows me that I failed to make clear the point of my criticism, and I trust that the great importance of accurate records of temperature will induce you to allow further discussion on the subject. I now have records of some 4000 children's temperatures, all taken with "30 second" tested thermometers, and have found that it is necessary to leave the thermometer in place for at least 10 minutes in order to be sure of really ascertaining the existence of pyrexia *in all circumstances*. In several hundreds of cases I have looked at the thermometers at the end of varying periods—e.g., 2–5 minutes, and have found that there was frequently a rise up to 10 minutes. The fact that the thermometer is "standard" does not affect the point. It depends partly on the temperature of the surrounding air and the stillness of it. If this temperature is below 56° F. I do not consider the oral method sufficiently accurate to make the results worth recording, however long the time, unless the mouth be kept closed (for at least 15 minutes), while the neck and cheeks are well covered with a warm "comforter." If the cheeks are very thin, or the child breathes partly through the mouth or has been running in frosty air so as seriously to cool the interior of the mouth, at least 15 minutes is required. With certain people (those with thick cheeks and entirely nasal breathing) the thermometer will record correctly in as little as one minute in a warm, still room. If due care is taken the differences between mouth and rectal temperatures need not exceed 0·2°–0·4°.

But if the temperature is taken in every patient, and under all circumstances, for a short period only, the result will be that pyrexia of over 1° will frequently be missed, and the daily variations recorded will depend mainly on the accidental variations of the mouth and of the environment.

I regret that I am obliged to write the following from memory without verifying the references. Since making my own observations I have found that similar criticisms or warnings to the above have been published by the following well-known clinicians, among others, Professor Sahli, Berne, in "Tuberculin Treatment" and in his System of Medicine; Dr. Marion Pottenger, San Francisco, both in his Text-book on Tuberculosis and in his recent "Tuberculin Treatment."

Dr. F. W. Burton-Fanning and Dr. S. G. Champion gave a careful analysis of many observations in a paper in your journal (for 1903),[1] and so long ago as 1830 John Davy, F.R.S. (Philosophical Transactions, London), drew attention to the need for such precautions as I have suggested. The absence of such precautions has induced many careful clinicians to regard the oral method as worthless.

If tuberculin treatment is to be undertaken we must rely mainly on oral temperatures, and I believe that many of the failures we hear of are due to the non-recognition of repeated reactions, owing to faulty methods of taking the oral temperature. The

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[1] THE LANCET, March 28th, 1903, p. 856

errors occur more readily with the slighter degrees of pyrexia, yet it is these we need to observe for the purpose.

Thanking you for your courtesy in inserting this,

I am, Sir, yours faithfully,

Cornwall, Nov. 16th, 1913. MARY H. WILLIAMS.

## WORKMEN AND HERNIA.

*To the Editor of* THE LANCET.

SIR,—In a letter in THE LANCET of Nov. 1st, Dr. A. P. Gibbons takes a pessimistic view of the results of the operation for the radical cure of hernia and criticises somewhat severely the selection of cases by the surgeons of London hospitals.

Like Dr. Gibbons, I have the opportunity of seeing a very large number of cases of hernia every year, but my conclusions as to the value of the radical operation are directly opposed to his. After reading his letter I went through the cards of the first 8000 male patients to attend at the City of London Truss Society after Jan. 1st, 1912. The majority of these had not been operated on, and as of course we do not see cured patients at the Truss Society the results have no real statistical value. However, if the number of patients in London with recurrences were really very large, one would expect the percentage of recurrences to patients seen to be much higher than it is.

The results of the examination are as follows: patients, 8000; recurrences, 191; percentage of recurrences, 2·3. Of these 191 recurrences it is noted that 24 were operated on for strangulation; others were severe cases in which an operation had been performed to enable a truss to be worn; some few had suppurated; two were patients in whom the hernia had appeared after an operation for appendicitis and where there was some muscular atrophy, probably due to nerve division; some dozen had been under the care of a surgeon who is known to perform an inadequate operation, and others had been operated on by comparatively inexperienced house surgeons. In many of the cases the men had returned to work within a few days of leaving the hospital. Several of the herniæ had recurred after long intervals of time—in one case 28 years.

Thus of the 191 cases a large number must be discounted before deciding that the radical operation is a failure. Of the same 8000 patients 41 had been operated on on one side without recurrence and presented themselves with a new hernia on the opposite side.

For some years there has been a diminution in the numbers of patients attending the institution, and this has been most marked in the decades in which the operation is most frequently performed.

| Age. | 1893. | 1912. | Decrease (per cent.). |
|---|---|---|---|
| Under 1 ... ... | 492 ..... | 133 ..... | 72·9 |
| 1–10 ... ... | 1085 ..... | 484 ..... | 55·3 |
| 11–20 ... ... | 578 ..... | 233 ..... | 59·5 |
| 21–30 ... ... | 1145 ..... | 489 ..... | 57·2 |
| 31–40 ... ... | 1558 ..... | 1028 ..... | 33·3 |
| 41–50 ... ... | 1798 ..... | 1504 ..... | 16·3 |
| 51–60 ... ... | 1630 ..... | 1479 ..... | 9·2 |
| 61–70 ... ... | 1146 ..... | 1063 ..... | 7·2 |
| 71–80 ... ... | 424 ..... | 386 ..... | 8·9 |
| 81–90 ... ... | 36 ..... | 40 ..... | 11·1 increase. |

This diminution dates from 1895—i.e., about the time from which dates the increasing frequency of the operation. Thus at St. Bartholomew's Hospital the operations for the radical cure of inguinal and femoral hernia in 1893 numbered 118, and in 1911 357, a similar increase occurring at all other hospitals. As this diminution is striking in the decades in which the operation is usually performed and runs *pari passu* with the increased frequency of the operation, one is, I think, justified in concluding that the majority of these patients have not only been operated on but cured.

I am, Sir, yours faithfully,

J. E. H. ROBERTS, F.R.C.S. Eng.

Devonshire-place, W., Nov. 12th, 1913.

## PROTECTION AGAINST X RAY BURNS.

*To the Editor of* THE LANCET.

SIR,—Your Paris correspondent last week (p. 1423) calls attention to a device introduced by Dr. Ménard of the Hôpital Cochin which was brought before the Academy of Sciences by M. Moureu, designed to afford a definitive protection against the X rays in the case of operators who have to use the rays for long periods. The essential feature is that the patient and the X ray tube are placed inside a special compartment lined with lead.

In January, 1910, four cabinets of this type came into use in the X ray treatment room at the London Hospital. The working of the apparatus is entirely controlled from outside the cabinets, and a cut-out is placed at the doors so that the operator cannot under any circumstances come into the field of the rays. Mr. A. E. Dean put in this installation from the designs of myself and my assistant, Mr. Blackall. Since January, 1910, more than 33,000 exposures have been made with absolutely no risk to the operators. A similar installation has recently been placed in the X ray department at St. Thomas's Hospital. I am, Sir, yours faithfully

JAMES H. SEQUEIRA.

Manchester-square, W., Nov. 17th, 1913.

## SULPHUR IN GAS.

*To the Editor of* THE LANCET.

SIR,—I have read with interest the annotation in THE LANCET of Nov. 1st upon the subject of sulphur in gas, and as it is one in which I have been deeply interested for many years, I trust you will allow me to supplement your statement.

The presence of sulphur in purified coal-gas was known quite early in its history, but Dr. Brande was the first to point out that the compound was the bisulphide of carbon. In 1860 the first Act of Parliament was passed fixing a maximum allowable amount for the impurity, and from that time onward large sums of money have been spent in complying with those regulations. The only practicable method of extraction was the so-called lime process which, apart from being very unsuitable, created a good deal of nuisance. When, therefore, a departmental committee presided over by Lord Rayleigh reported that the removal of the carbon bisulphide was unnecessary, the companies hastened to revert to purification by oxide of iron, but, as you correctly state, they have since partially gone back to lime.

Nearly six years ago the chief chemist of the South Metropolitan Gas Company was instructed to investigate *de novo* the whole subject of gas purification, and in the end a process based upon one suggested many years ago by Professor Vernon Harcourt was tried on the large scale. The experiment was successful, and at our second largest works the whole of the gas made there, amounting to about 10,000,000 cubic feet daily, has been for some months past purified from every trace of

carbon bisulphide. The process is being extended to the remainder of our works, and in a year's time the whole of the gas supplied by this company will be completely purified from the bisulphide, treatment for which has so long baffled chemists and scientists. The full advantage as a steriliser of the bunsen flame used in incandescent gas lighting will thus be obtained in our living and sleeping rooms without any disadvantage arising from any excess of sulphurous acid from the products of combustion which it is not possible to guarantee when only oxide of iron is used.

I am, Sir, yours faithfully,

CHARLES CARPENTER.

South Metropolitan Gas Company, S.E.,
Nov. 12th, 1913.

*** This is a gratifying endorsement. It is most satisfactory to learn that one of our great gas-making companies intend soon to supply the whole of their gas entirely free from sulphur compounds. Great sanitary advantages in the domestic use of gas will follow, and a very large amount of destruction will cease to occur that undoubtedly occurs now in domestic fittings—e.g., books, metal ornaments, burners, curtains, ceilings—by sulphur in the gas. We congratulate the South Metropolitan Gas Company on their policy, and we recommend Dr. Carpenter's letter to the attention of that usually sensible trade organ, the *Journal of Gas Lighting and Water Supply*. The manners and intelligence of that journal deserted it last week.—ED. L.

## BIG GAME AND SLEEPING SICKNESS VERSUS MAN AND HIS ANIMALS.

*To the Editor of* THE LANCET.

SIR,—Everyone who is concerned with the development of Africa and with the study of those diseases which have been the greatest of the obstacles preventing the colonisation of tropical countries by Europeans must be deeply interested in the papers published by Kinghorn and Yorke, and by the discussions which their papers have occasioned.

Some of the work on which Kinghorn and Yorke base their advice that big game should be destroyed in areas near settlements has led to results which are not quite in accordance with the experience of those who have worked on human trypanosomiasis in East and in West Africa; these differences are probably attributable to varying conditions of the localities in which the observations were made. The correctness of their work and of the facts which their work makes evident is unquestioned. The situation is clear: big game—especially antelopes—are the reservoirs of, and Glossina morsitans is the carrier of, trypanosomes which cause fatal diseases in men and animals; there is no efficient means of destroying the fly nor of curing the diseases caused by the parasite. The only means which offers any immediate promise of controlling the situation is the destruction of the reservoirs. The clear-cut directness of the reasoning is striking; no less striking is the sufficiency of the ascertained facts with which arguments proffered against it can be met.

Such is the situation. The nature of the action which it prompts should depend upon the ultimate object of our racial activity in Central Africa. If it is to open up more areas to permanent, thrifty European colonisation, then the game must go—for the present, at all events. Perhaps through inherited centuries of habit and tradition, the impulse to preserve game is an imperative social instinct to most Europeans; consequently, a suggestion that game should be exterminated inevitably excites hostile prejudice in most of us. But the question is too serious a one for us to allow ourselves to be swayed by any such emotion; reason alone must decide it. However agreeable a little shooting may be, no real settler will hesitate for long in choosing between the game and his domestic animals. Nor will those who are not settlers regret the loss of licence fees and of a wonderful playground, nor will they regret even the destruction of an interesting fauna in the building up of permanent European settlements in the tropics.

In view of the facts it is reasonable to carry out the experiment which Dr. Yorke proposes. I give it the whole-hearted support of many years spent in the study of trypanosomiasis (nearly four of them in Africa); the support is given the more readily since Dr. Yorke expressly limits the proposed destruction to a comparatively small area. The experiment, as Dr. Yorke outlines it, would soon show whether it were possible to prevent trypanosomiasis by the destruction of the big game in a limited area. And it would provide an opportunity to those engaged in carrying it out for supplying much-needed replies to many of the unanswered questions concerning trypanosomiasis and its transmission. Among the most important of them are questions concerned with the duration of trypanosome infections and with the existence and production of immunity in them. Answers to these questions, or to others concerning the bionomics of tsetse flies, can only be obtained by observations made in Africa over a period of years by competent persons.

I am, Sir, yours faithfully,

J. L. TODD.

## THE DUTIES AND STATUS OF THE SCHOOL MEDICAL OFFICER.

*To the Editor of* THE LANCET.

SIR,—There has been a feeling of discontent for some time past among the majority of those actually engaged in the work of medical inspection of school children. In the greater number of areas an undue proportion of the work of these officers consists in the routine inspection of a large number of children, a considerable proportion of whom present no feature of especial interest to a medical man. The salary offered for the work is usually inadequate; the initial salary is in most cases too low; rarely is the increased value of the services of the officer acknowledged by an adequate increase in his or her salary. In a few areas, including Bradford and Brighton, this state of affairs either has not existed or has already been altered; arrangements have been made so that the medical officers actually inspecting the children are only required to inspect a reasonable number of children in the year, the rest of their time being taken up in treatment, &c. The grievance of inadequate salary is remedied to a certain extent in both these areas.

A feeling also exists that the result of the increased activity of the public health world in the last few years has been the creation of a large number of subordinate officials for whom there is but little outlook. In order to improve the status of the officers engaged in the school medical service

an organisation has been formed within the Society of Medical Officers of Health. The advantages of this course over those of forming a separate association for the purpose are that the society can offer the benefits of many years of experience of organisation; it has funds at its disposal and a journal; in addition, many of those engaged in the school medical service are already members of this society. All those engaged in the service of education committees, either in an administrative capacity or as medical inspectors of school children, are eligible for membership of the group if members of the Society of Medical Officers of Health. Membership of this society is open to the same class of the medical profession, including ladies, who are especially welcome.

The improvement of the status of the school medical service is a matter requiring careful handling by experienced persons. Prominent members of the Society of Medical Officers of Health have already afforded valuable service to the movement. Mr. Herbert Jones, one of the secretaries of the society, undertook the duties of chairman at the initiatory meeting; Dr. Alfred Greenwood, county medical officer of health and school medical officer for Kent, presided at the first meeting of the group.

In order to avoid the unnecessary inconvenience and expense involved by attending meetings in London, it is desirable that groups of officers engaged in the school medical service should be formed in the branches of the Society of Medical Officers of Health. The arrangements for these groups would, of course, be made by the local members. The opinion has, however, been expressed by several who would become members of the branches that it would be desirable to hold the meetings on the same day as the ordinary meetings of the branch in order to avoid multiplicity of journeys. In order to link up the groups in the branches with the central group, it has been arranged that the executive committee shall include, in addition to the chairman, secretary, and treasurer, a representative elected by each of the groups formed in the branches. It has also been suggested that the groups might with advantage adopt as an item of their policy the following extract from the criticism of the Board of Education on the School Medical Service in London.

The Board suggested that:

Each assistant medical officer should be entrusted with other kinds of work, for example, the further examination of visual defects, public health work, including investigations of infectious diseases in schools, the medical inspection of children in secondary schools, scholarship candidates, &c., work in connexion with the special schools, research and laboratory work, and some share in the working of the administrative arrangements. The work of treating minor ailments arises naturally out of the work of the inspection centre and could most effectually be carried out in intimate conjunction with the work of the inspection centre by the officers responsible for that work.

The movement is not necessarily in favour of a school medical service independent from the public health service or a school medical service *ad hoc*. Certain of the members of the group have, indeed, expressed themselves strongly as to the necessity of making all assistant school medical officers not only nominally but actually assistant medical officers of health.

It is hoped that as many as possible of those eligible for membership of the group will attend the next meeting to be held on Saturday, Dec. 6th, at 2 o'clock, at 1, Upper Montague-street, Russell-square, London, W.C.

I am, Sir, yours faithfully,

C. W. HUTT, M.A., M.D. Cantab., D.P.H. Oxon.,
Senior School Doctor, Brighton; late Assistant Medical Officer of Health, Warrington.

School Clinic, 7, Gloucester-place, Brighton, Nov. 15th, 1913.

## POLIOMYELITIS IN ENGLAND.

*To the Editor of* THE LANCET.

SIR,—To the remarks on acute poliomyelitis in THE LANCET of Nov. 15th please allow me to add a few more. In the summer of 1910 there were ten cases of poliomyelitis in my practice in Carlisle, in February, 1912, one case, and in October of this year one case. Two of the patients had a rash on the abdomen resembling the scarlet fever rash during its fading stage. One patient that died had from the commencement of the disease an inflamed throat with a white spot on one tonsil.

The majority of the cases occurred in houses inhabited by the poorer class of workers and infested with flies, fleas, and lice. These vermin may be connected with the origin of the disease, but in the streets where my cases were I have at times found very foul odours, and I know that the children are allowed to crawl about the doorways and along the kerb, where they can inhale directly any poisonous smells arising from the street.

I am, Sir, yours faithfully,

Carlisle, Nov. 16th, 1913. MALCOLM STEWART.

## "TWINS" OR SUPERFŒTATION?

*To the Editor of* THE LANCET.

SIR,—In consequence of the maternity benefit connected with the National Insurance Act the daily press has brought to the notice of the general public a question of the greatest scientific interest, as within the last 12 months apparently, two mothers have each respectively given birth to two children, with in one case an interval of five weeks and in the other an interval of six weeks between the children. The problem which attracts scientific attention and calls for solution is: Are the children thus born to be regarded as twins or not? We know that true twins may exhibit at birth a marked disparity both in size and development, but it is impossible to believe that two ova impregnated at the same time and lodged in the same uterine cavity can be so influenced that one completes its uterine development and growth and is expelled from its maternal abode 35 or 42 days after its fellow. It is quite possible that two ova may be shed and impregnated at different times during the same inter-menstrual period, but the offspring thus begotten will be born at practically the same time. The question which now confronts us is: Is true superfœtation possible? That is, is it possible for an ovum to be fertilised 35 or more days after the process of gestation has asserted itself in a previously fertilised ovum? As ovulation occurs whilst menstruation is held in abeyance by lactation, there is no apparent reason why ovulation may not occasionally occur during gestation, and under such circumstances superfœtation is possible, and the mother who gives birth to two children which are born after a greater interval than 28 days is clearly entitled to the maternity benefit for each.

I am, Sir, yours faithfully,

JAMES OLIVER, M.D., F.R.S. Edin.

Harley-street, W., Nov. 15th, 1913.

## THE HONORARY STAFF OF THE MOUNT VERNON HOSPITAL AND THE COMMITTEE OF MANAGEMENT.

*To the Editor of* THE LANCET.

SIR,—In your issue of July 12th you published a letter under this heading signed by certain members of the honorary medical staff of this hospital in which they resign their appointments as a protest "against the attitude which for the past few months the committee of management has adopted in reference to the medical board, and its recommendations." This letter also appeared in the *Times* newspaper on July 10th, where it was replied to by me as chairman of the committee.

It appears that I should have replied to this letter in THE LANCET, but having dealt with it in the *Times* it seemed to me to be unnecessary to repeat myself. However, as certain statements have been made, and as the interests of the hospital are gravely prejudiced by the issue of warning notices and by the circulation of statements which are without foundation, it is necessary for me to ask you to allow me to refer to the matter in your columns. I am informed that the issue of the warning notice is based upon two assertions: first, that the two junior members of the honorary medical staff, Dr. F. W. Price and Dr. A. J. Whiting, had been dismissed from their appointments; and second, that in view of the expressed desire of the committee to place the beds at Northwood in the hands of the senior members of the staff, an injustice had been done to Dr. Tunnicliffe, the senior member of the honorary staff, who, it is said, was not offered beds at Northwood. It is, therefore, with these statements that I wish to deal. With your permission I will repeat what I have said elsewhere as to the original statements contained in the letter of resignation. In the first place it is untrue to say that any members of the staff were dismissed. This is proved by the simple fact that they resigned their positions more than two months after the alleged "dismissals," one of them meanwhile retaining his seat as a member of the committee. The duty of visiting the patients at Northwood was allotted to them for one year, and that period had long expired. It must be remembered that the Mount Vernon Hospital consists of the two establishments at Hampstead and Northwood respectively, and the out-patient department at Fitzroy-square, and there was never any appointment to one of them exclusively. It is all one institution, and the by-laws provide that the allocation of the duties of the honorary medical staff rests entirely with the committee of management. The medical staff are represented by two of their number at the meetings of the general committee as members of that committee, and one of them, Dr. Tunnicliffe, was present at the committee meeting on March 19th, when I gave notice of motion in regard to the new appointments. It was on this date that Dr. Tunnicliffe on hearing me give notice of the motion asked to be excused from visiting Northwood, so at his request I withdrew his name. Dr. Tunnicliffe reported to the medical board on April 1st all that had transpired at the committee meeting. At the following meeting of the committee of management on April 16th I moved the appointment of the senior physicians, omitting Dr. Tunnicliffe's name, to the care of the beds at Northwood, and the motion was carried unanimously. In regard to the statement of Dr. Tunnicliffe in the *Times* that beds were not offered to him as senior acting physician, the facts are as I have stated. While it is true, therefore, that at the meeting of April 16th Dr. Tunnicliffe was not included in the list of physicians to whom beds were allotted, it is equally true that the omission was of his own seeking because of his strongly expressed objection to undertake the duty. The whole of these circumstances are in the recollection of the members of the committee present on that occasion.

The other matter which demands attention is the statement that a request was made for a conference to discuss the new appointments and *other questions*. No such demand was ever made. On May 6th the medical board demanded a conference to discuss the appointments which had already been made, but there never had been a request to discuss *any other question*. My committee therefore naturally declined to reopen a question which had been disposed of by them by a unanimous vote, and which was wholly within their province.

I am, Sir, yours faithfully,

C. JOHNSTON,
Chairman of the Committee.

7, Fitzroy-square, London, W., Nov. 18th, 1913.

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## THE GOVERNMENT OF THE ROYAL COLLEGE OF SURGEONS.

*To the Editor of* THE LANCET.

SIR,—One day last week I received by post, addressed to me as "Dr.," a title to which I have no claim, a pathetic but amusing letter from a gentleman unknown to me, who drew a touching picture of my sad condition as a Member of the Royal College of Surgeons. He assured me, with all the emphasis which capital letters could supply, that in College matters I have *NO* vote and *NO* rights, that he and others are "fighting" to give me both, and that a contribution to the war chest would be accepted. I am deeply grateful to these champions of my cause for their solicitude; but in the fiftieth year of my Fellowship I am compelled to regard their labours in my behalf as superfluous, and I most sincerely hope that their "fighting" will not expose them to any risk of injury. At the same time, I should be glad to place on record my conviction that the change which they advocate would be highly prejudicial to the status and progress of surgery in this country, and therefore in the long run highly disastrous to those who practise it. The chief object of the College, as I understand it, is to maintain in England the highest possible standard of what (in contradistinction to *minor*) may be called "major" surgery, such as is commonly practised by Fellows and only seldom by Members. A transference of the government of the College to the latter body would almost certainly cause this chief object to be more or less set aside in favour of others which, however desirable in themselves, would be better sought through the agency of some other organisation. The supposed "claim" of the Members is supported by a money plea, which is even more fallacious than it is ignoble. The question is not one of money, but of the promotion of science; and, even if this were not so, it must be remembered that every Member obtains value for his payment in the shape of a legal qualification, and that nearly every Fellow has paid his fee for the grade, not in substitution for that for the Membership, but in addition to it. Moreover, in the name of common

sense, if any Member of the College wishes to vote for the Council, or to become eligible to sit therein, why does he not qualify in the proper manner? I had this wish, being then a general practitioner in a rural district; and so, as soon as I had completed the required 12 years of Membership, I presented myself for the Fellowship examination and got what I wanted. If any Member really desires the privileges of a Fellow the only unsurmountable impediment to obtaining them is idleness or ignorance.

I am, Sir, yours faithfully,

R. BRUDENELL CARTER.

Clapham Common, S.W., Nov. 17th, 1913.

## THE NATIONAL INSURANCE ACT.

*To the Editor of* THE LANCET.

SIR,—There are many very objectionable features about the new Draft Regulations for Medical Benefit, but the Draft Agreement contains one clause so intensely objectionable that the whole profession ought to rise as one man and demand either its instant deletion or radical alteration. The clause referred to, 2 (11), reads as follows:—

> The practitioner shall not accept any fee or other remuneration in respect of treatment which he is required to give under this agreement, except as provided in this agreement.

I am, Sir, yours faithfully,

T. CUMING ASKIN, M.D. Dub.

Alderton, Woodbridge, Suffolk, Nov. 18th, 1913.

## VAGITUS UTERINUS.

*To the Editor of* THE LANCET.

SIR,—I was much interested in reading your annotation on the above subject in THE LANCET of Nov. 8th. It recalled to my mind an undoubted case that occurred in my own practice some years ago. There could be no possible doubt about it as it was heard as distinctly by the nurse as by me. The cry was quite loud. The case was a breech occurring in a primipara. The labour was allowed to pursue a natural course without interference until sufficient of the breech was delivered to allow me to grasp it with both hands to make traction on it so as to hurry the head through the pelvis. It was during this manœuvre that the cry occurred. I did not have any of my hand in the vagina then except my two forefingers, as they secured purchase round the iliac crests of the child; in that way perhaps air was allowed to enter. The child was born alive, and I did not think it necessary to rush matters at the expense of the integrity of the mother's tissues. Even the perineum was not injured.

The causes that seemed to me to operate for its production, allowing for the necessity of air, were the pressure of the head on the cord and the stimulation of cold air on the child's breech. I thought perhaps this case would interest other readers of THE LANCET.—I am, Sir, yours faithfully,

Kettering, Nov. 12th, 1913. D. D. LEE.

## LONDON NERVE CLINIC (SCHOOL OF PSYCHOTHERAPY).

*To the Editor of* THE LANCET.

SIR,—Can you grant me a few lines of your valuable space to make it known that the "London Nerve Clinic" (School of Psychotherapy) is in no way connected with any organisation, institute, or clinic, staffed either by medical or lay workers, in which psychotherapeutic methods are carried out? Although offering treatment on psychological lines to patients of small means, as well as to the very poor, this clinic is entirely independent of outside financial support.

I am, Sir, yours faithfully,

EDWIN ASH,
Director.

71, Baker-street, W., Nov. 15th, 1913.

## THE NATIONAL INSURANCE ACT.

### THE NEW DRAFT REGULATIONS FOR MEDICAL BENEFIT AND MR. DANCKWERTS'S OPINION.

THE Draft Regulations to be cited when they come into force as the National Health Insurance (Medical Benefit) Regulations (England), 1913, provide, as was stated in THE LANCET of Nov. 15th, p. 1433, means for avoiding in future the difficulty produced hitherto by the accumulation of funds in respect of insured persons who have not selected their medical attendant, and who have not been (and who often cannot be) allocated to medical men on the panel at a particular time in a particular quarter. These funds are to be distributed where there is a capitation system "to such of the practitioners on the panel and in such proportions as are agreed between the Committee and the Panel Committee, or in default of agreement as the Commissioners may determine." Where there is payment by attendance each practitioner is to be credited with the amount found to be due to him for work done, and is to receive "an amount bearing the same proportion to the sum credited to him as the amount in the Practitioners Fund (after deducting any sums payable out of that fund to the Central Medical Benefit Fund or set apart for mileage) bears to the aggregate amounts credited to all the practitioners." The regulation, of which the more essential parts only have been given above, provides for future occasions—that is to say, for funds arising in respect of unallotted persons after the new regulations come into force on Jan. 12th, 1914, and apparently is not intended to affect in any way funds already accumulated. This regulation may be regarded as a result of the decisive opinion expressed by Mr. Danckwerts, K.C., when consulted by the London Insurance Committee, but as not affording a solution for the difficulty to which he drew attention. It will be remembered that the opinion referred to was obtained by the London Insurance Committee, and that Mr. Danckwerts was advising that body only as to the circumstances in which it then found itself placed. He was not advising the Insurance Commissioners, nor did he express any opinion as to their powers to find a solution for the difficulty which he pointed out as existing under the Act of 1911 and under the regulations then in force. He went no further, in short, than to say in his answer to a question asking for general advice on the situation: "The committee should not touch this fund as long as matters stand as they are now." The difficulty of allotting all the persons in a given district of any considerable size, in respect of whom premiums are being received, to a medical man on the panel, so that there are at no time any potential patients unallotted, amounts practically to impossibility, but it is pretty evident that it escaped notice when the Insurance Act, 1911, was passed. Therefore no mention is made of it in the Act, and authority to frame regulations with regard to it is

not specifically given. By Section 65 of the Act, however, the Insurance Commissioners are given power to make regulations for any of the purposes for which regulations may be made under Part I. of the Act, and "generally for carrying this part of this Act into effect," and by Section 15 every Insurance Committee is compelled to make arrangements with medical practitioners in accordance with regulations made by the Insurance Commissioners. Presumably, therefore, anything ordered or authorised by the Commissioners can be done without fear of consequences by the Insurance Committees. Regulations, moreover, have effect as if enacted in the Act. The form of laying them before both Houses of Parliament as soon as may be after their being made does not have to precede their coming into force, although through an address presented within a prescribed period to His Majesty by either House they may be annulled afterwards.

### THE ACCUMULATED FUNDS IN LONDON.

In a speech made at the first annual meeting of the New Tabernacle Approved Society Mr. Kingsley Wood, a member of the London County Council and of the National Insurance Advisory Committee, made the suggestion that the fund accumulated through the failure of the London Insurance Committee to allot insured patients who have not chosen their medical attendants should be devoted to establishing a nursing scheme for London. He qualified this to the extent of saying that a portion of the fund might in fairness be distributed to medical men on the panel, and he made observations, which no doubt were fully justified, on the benefits which a nursing system for the care of insured patients might be expected to produce. Medical men, however, certainly will not acquiesce willingly in the appropriation to a nursing scheme, or to any other such project, of money paid under legal compulsion by the working-classes with a view to the remuneration of medical men for their work under the Insurance Act, and any such diversion of funds from their original destination could hardly be sanctioned for London unless a similar diversion were to be authorised equally elsewhere. The question, in short, concerns the medical profession practically throughout the country, and the suggestion made by Mr. Wood appears to be at present merely an idea of his own propounded at a convenient moment to an audience not likely to express dissent. To carry it out would require, it is submitted, the passing of an Act of Parliament with that object.

### THE NORFOLK INSURANCE COMMITTEE: THE ALLOCATION OF ACCUMULATED FUNDS.

At a recent meeting of the Norfolk Insurance Committee great satisfaction was expressed at the success which had attended the committee in allocating to the lists of medical men on the panel all the insured who had not exercised their right of choice in the matter. The Medical Benefit Subcommittee referred in eulogistic terms to the cordial coöperation of the medical practitioners who had assisted in effecting the arrangements made with a minimum of friction and inconvenience. The same subcommittee also stated that arrangements had been completed for the working throughout the county of both green and yellow vouchers; that it had secured from the Insurance Commissioners a notification of the provisional allocation to it of a substantial sum in respect of special mileage, that the provision of medical benefit was satisfactory throughout the county, and that the number of practitioners on the panel was increasing. Very few applications had been received from persons desiring to make their own arrangements, these being considered separately on their merits, and in the absence of proper and adequate reasons refused. It was recommended by the Medical Service Subcommittee that its numbers should be increased to five medical men and five insured persons.

### APPROVED SOCIETIES AND EXPENSES OF ADMINISTRATION.

The question of the financial adequacy of the provisions of the Insurance Acts is at present occupying the attention of the officials of the Approved Societies, with special reference to the amount, 10½*d.* per member per quarter, allowed for administrative expenses. Even in societies where the closest attention has been paid to economy in administration it has been found very difficult to keep within this limit, and the smaller societies are naturally more affected than the larger. It has been suggested that the raising of the quarterly sum for administration from 10½*d.* to 1*s.* per head would diminish the difficulty felt, and would not be in any way too large an increase.

### THE LONDON MEDICAL COMMITTEE.

At a meeting of the London Medical Committee (non-panel) on Nov. 17th notice was received of the formation of a non-panel association for Deptford. A resolution was passed expressing the opinion that the domiciliary treatment of tuberculous persons, as well as that carried out in local dispensaries, ought to be entrusted, to the fullest possible extent, to practitioners engaged in general practice. Among other resolutions was one suggesting that the newly appointed Non-panel Committee of the British Medical Association should endeavour to obtain an injunction against the London Insurance Committee distributing the medical benefit of unallocated insured persons amongst the practitioners on the panel.

### SHOREDITCH MEDICAL UNION.

A special meeting of this society, which includes in its membership the majority of the practitioners resident in the area of the borough of Shoreditch, took place on Nov. 14th at the Metropolitan Hospital, in order to nominate candidates for the Panel Committee about to be elected in the county of London. More than 75 per cent. of the local profession were present. Dr. Major Greenwood, the president, pointed out from the chair that as the Panel Committee would be elected by the London practitioners generally who were on the panel, there was little chance of there being an adequate representation of the local profession in the various constituent boroughs of the metropolis. But the Panel Committee was likely to become the Local Medical Committee for London under the amended Insurance Act, for he thought there was little likelihood of the committee, in the election of which the Metropolitan Branch of the British Medical Association was now engaged, being recognised by the Insurance Commissioners. After some discussion it was decided to nominate three panel practitioners and one non-panel, and the following were unanimously chosen and duly

nominated:—Dr. Major Greenwood, Mr. Alban Dixon, Dr. G. E. Froggatt, and Mr. J. H. Porter. The honorary secretary was instructed to send in to the returning officer these nominations, and to say they were chosen at a specially convened meeting of the Shoreditch profession; and to add that it was the opinion of that meeting that, when the nominations in the County of London were published and sent to the electors, after each candidate's name there should be placed the name of the borough he would represent; for if this were done it would be possible for the electors to see that as far as possible all boroughs might have some representation.

### THE SUPPLY OF MEDICINES BY MEDICAL MEN TO INSURED PERSONS.

At Halifax a question has arisen and been discussed publicly in the newspapers with reference to a case or cases in which medical men asked to supply medicines instead of giving prescriptions to be made up by druggists, have apparently dispensed without making it clear to the patient that in such circumstances he will be expected to pay for the medicine supplied. A patient has stated that she "had been under treatment by her panel doctor and had complained to him regarding the quality of the medicine supplied by the chemist, and he admitted himself that it was not right." The patient thenceforward got her medicine from the medical man and afterwards received a bill for it amounting to 22s. Apparently someone consulted by her advised her to pay this, which no doubt would be correct advice if it were shown that an arrangement was made to that effect. A lady member of the Halifax Insurance Committee has, however, written to the newspapers stating that in any such circumstances she would advise the patient not to pay and to report the matter to the clerk of the Insurance Committee of the district for inquiry. Mention is here made of the matter because the possibility of such a case occurring at any time is obvious, and because medical men should have their attention drawn to the necessity for making a patient clearly understand that if the practice sanctioned by the Act is departed from at the patient's request it must be also at his expense.

### A PROTEST AGAINST A SANATORIUM FOR TUBERCULOSIS.

The Surrey county council and the Local Government Board are, it is stated, being appealed to by residents at Telford, near Farnham, on account of the increase of patients at a private sanatorium in their district due to the treatment of tuberculosis under the Insurance Acts. A memorial complains that patients from other counties are being treated and that these come into contact with the inhabitants by meeting them on the roads, in the post-office, and elsewhere. The protest has secured the support of the Farnham rural district council, and a similar one is said to be in course of being promoted at Crooksbury, where, however, the patients are from Surrey.

### THE LATE DR. HORACE DIMOCK.

At a meeting of Cambridge and Huntingdon medical men on Nov. 8th a resolution was passed expressing deep concern at the possibility that no public inquiry will be held into the recent disturbances at Wisbech. A copy of the resolution was forwarded to the Home Secretary and the Insurance Commissioners.

# Medical News.

UNIVERSITY OF OXFORD.—The following medical degrees have been conferred:—

*D.M.*—H. G. Butterfield, Wadham; A. F. S. Sladden, Jesus; and L. T. Burra, University College.

UNIVERSITY OF CAMBRIDGE.—At a congregation held on Nov. 8th the following degrees were conferred:—

*M.D.*—H. L. Duke, Caius; and P. K. Gilroy (by proxy), Selwyn.
*M.B. and B.C.*—H. C. Attwood and H. J. Couchman, Caius.
*B.C.*—F. G. Rose, St. John's.

The number of medical students who have entered Cambridge University this year is 116. In 1911 the number was 114, and in 1912 110.

ROYAL COLLEGES OF PHYSICIANS OF LONDON AND SURGEONS OF ENGLAND.—At a meeting of Comitia of the Royal College of Physicians on Oct. 30th and of the Council of the Royal College of Surgeons on Nov. 13th diplomas of L.R.C.P. and M.R.C.S. were respectively conferred upon 105 candidates who have passed the Final Examination in Medicine, Surgery, and Midwifery of the Conjoint Board, and have complied with the by-laws. The following are the names and schools of the successful candidates:—

Charles Sydney Archer, Leeds University, London Hospital, and Sheffield University; William Stuart Armitage, St. Mary's Hospital; Charles Sydney Atkin, B.A. Cantab., Cambridge University and St. Bartholomew's Hospital; Francis Gordon Bell, M.D., Ch.B. Edin., Edinburgh University; Frederic Vivian Bevan Brown, Guy's Hospital; Walter Grimshaw Bigger, B.A. Cantab., Cambridge University and St. Thomas's Hospital; Geoffrey Andrew Bird, B.Sc. Lond., St. Thomas's Hospital; John Bostock, London Hospital; George James Bowen, University College, Cardiff, and St. Thomas's Hospital; Harold James Bower, B.A. Cantab., Edwin John Bradley, B.A. Cantab., and Edward Henry Pollock Brunton, B.A. Cantab., Cambridge University and St. Bartholomew's Hospital; Noel St. John Grey Dudley Buxton, University College Hospital; Joseph Byrne, M.D. Columbia, Columbia University and Middlesex Hospital; Edward Worrell Carrington, B.A. Oxon., Oxford University and King's College Hospital; Frederick Sutton Charnock, Manchester University; Ferozeshah Bapuji Chenoy, L.M.S. Bombay, Bombay University and London Hospital; Frank Cook, M.B., B.S., B.Sc. Lond., Guy's Hospital; George Malcolm Coope, Manchester University; Eliezer Coplans, Liverpool University, St. George's and St. Mary's Hospitals; Charles Harold Crawshaw, Manchester University; William Llewellyn Gwyn Davies, Guy's Hospital; Howard Vipond Deakin, B.A. Cantab., Cambridge University and University College Hospital; Henry Speldewinde de Boer, Ceylon Medical College and London Hospital; Hubert Roy Dive, St. Bartholomew's Hospital; Arthur Rawdon Carrington Doorly, St. Thomas's Hospital; Edwin John Eacrett, M.B. Toronto, Toronto University and University College Hospital; Arthur Tudor Edwards, B.A. Cantab., Cambridge University and Middlesex Hospital; Hassan el Arculli, M.B., Ch.B. Liverp., Liverpool University; Abraham Solomon Erulkar, Guy's Hospital; Alexander Rentoul Esler, St. Thomas's Hospital; Walter Stuart Evans, University College Hospital; James Millar Evatt, B.A. Cantab., Cambridge University, St. Bartholomew's and University College Hospitals; Barcroft Joseph Leech Fayle, Cambridge and Bristol Universities; Meredydd Ffoulkes, St. Thomas's Hospital; Allen Coulter Hancock, Guy's Hospital; Robert John Harley-Mason, Middlesex Hospital; Frederick Theophilus Hill, St. Bartholomew's Hospital; Thomas Albert Hindmarsh, M.B. B.S. Durh., Durham University; Edmund Walter Neill Hobhouse, B.A. Oxon., Oxford University and St. Thomas's Hospital; *Arthur Norman Hooper, Cambridge and Birmingham Universities; Rev. Oswald Ryle Horwood, M.A. Cantab., Cambridge University and London Hospital; Harry Fleming Hutchinson, M.B., Ch.B. Vict., Manchester University; Thomas Hitchings James, London Hospital; George Batteraby Jameson, Manchester University; Frank Edwin Johnson, London Hospital; Richard Bertram Johnson and Claude Kingston, Bristol University; John Iles Francis Knight, London Hospital; Norman Claudius Lake, M.D., B.S., B.Sc. Lond., Charing Cross Hospital; James Lafayette Lauder and John Llewellyn David Lewis, Guy's Hospital; Charles Cooper Ling, London Hospital; William Howard Lister, University College Hospital; Geoffrey Trevor Loughborough and Oscar Gladstone Maginness, St. Bartholomew's Hospital; Dalton Mallam, London Hospital; Gerald Noel Martin, London Hospital and Sheffield University; Edward Elton Mather, B.A. Oxon., Oxford University and St. Bartholomew's Hospital; Horace Mather, Guy's Hospital; John Millard, Birmingham University; Georg Herman Monrad-Krohn, M.D. Christiania, Christiania and Berlin Universities; James York Moore, Guy's Hospital; William Morris, London Hospital; John Tertius Morrison, M.B., Ch.B. Edin., Edinburgh University; *Margaret Clare Murphy, M.B. Calcutta, Calcutta University; Michael Brendan O'Sullivan, M.B., B.S. Melb., Melbourne University and Middlesex Hospital; Henry Barton Owens, London Hospital; Henry William Parnis, M.D., B.Sc. Malta, Malta University; William Percivall Penhale, Middlesex Hospital; Vernon Charles Pennell, B.A. Cantab., Cambridge University and St. Thomas's Hospital; John Abraham Perera, Ceylon Medical College and University College Hospital; Arthur Starkie Plant, Manchester University; John Precopoulos, Charing Cross Hospital; Edward Rayner, B.A. Cantab., Cambridge University and St. Thomas's Hospital; Sydney Jessie Scott Reid, Royal Free Hospital; Evelyn Ritson, Durham University; Cedric Sydney Lane Roberts, Guy's Hospital; William Eric Roper Saunders, St.

Bartholomew's Hospital and Durham University; Arthur Edward Schokman, Ceylon Medical College and London Hospital; Leonard Ernest Steigenberger Sharp, B.A. Cantab., Cambridge University and St. Thomas's Hospital; George Douglas Sherwood, B.A. Cantab., Cambridge University and Middlesex Hospital; *Jagannath Vishnu Shirgaokar, Bombay University and Middlesex and Charing Cross Hospitals; Algernon Charles Stanley Smith, B.A. Cantab., Cambridge University and St. George's Hospital; Arthur Joseph Eagleton Smith, Guy's Hospital; Henry James Drew Smythe, Bristol University; Alan Ker Soutar, B.A. Cantab., Cambridge University and St. Mary's Hospital; Thomas Sidney Stafford, Birmingham University; William Allan Stewart, London Hospital; John Weston Stretton, B.A. Cantab., Cambridge University and St. Bartholomew's Hospital; William Vere Taylor Styles, L.D.S. Eng., Middlesex Hospital; William Edward Tanner, Guy's Hospital; John William Thomas, Leeds University; Joseph Alexander Tsoi-A-Sue, London Hospital; Frederick Charles Turnbull, M.D. Jefferson, Jefferson Medical College and London Hospital; Chunilal Bhimbhai Vakil, Bombay University and St. Bartholomew's Hospital; Walter Heinrich von Wyss, M.D. Zürich, University of Zürich and University College Hospital; John Glen Wardrop, B.A., University College Hospital; Clement Wheeler Wheeler-Bennett, B.A. Oxon., Oxford University and St. Thomas's Hospital; Charles Eustace Williams, L.D.S. Eng., Charing Cross Hospital; Harold Austin Williams, B.A. Cantab., Cambridge University and University College Hospital; Frederick Edward Saxby Willis, St. Bartholomew's Hospital; Cecil William Wilson, London Hospital; Henry Goodwill Wiltshire, B.A. Cantab., Cambridge University and King's College Hospital; and Herbert Gregory Winter, London Hospital.

* Diploma of M.R.C.S. conferred on Oct. 9th.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—At the Primary Fellowship Examination in Anatomy and Physiology, held on Nov. 5th, 6th, 11th, 12th, 13th, and 14th, for which 129 candidates presented themselves, of whom 44 were approved and 85, or 66 per cent., were rejected, the following candidates were approved:—

Robert George Bannerman, M.A. Edin., Edinburgh University and London Hospital; Sydney Guy Billington, M.B., B.S. Lond., Birmingham University; Thomas Jacob Cobbe, M.B., B.Ch., B.A.O., R.U.I., Trinity College, Dublin; Hugh Emlie Coleman Collins, University College, Cork; Ralph Marsh de Mowbray, M.R.C.S., L.R.C.P., St. Thomas's Hospital; Ismail Fahmy Dlay, Cairo and King's College; Eric Hastings Eastwood, Liverpool University; George William Marshall Findlay, Edinburgh University and London Hospital; Alfred George Timbrell Fisher, M.B., Ch.B. Bristol, M.R.C.S., L.R.C.P., Bristol University and St. Bartholomew's Hospital; John Andrew Cairns Forsyth, M.Sc., M.B., Ch.B. Vict., Leeds University and Middlesex Hospital; Henry Hilton Monk Gould, B.A. Cantab., Cambridge University and St. Mary's Hospital; Hugh Ernest Griffiths, St. Bartholomew's Hospital; Ronald Montagu Handfield-Jones and Walter Leopold Holyoak, M.D., B.S. Lond., St. Mary's Hospital; Howard Tomlin Hunter, M.B., B.S. Durh., Durham University and St. Bartholomew's Hospital; Lancelot George Jacob, B.A. Cantab., Cambridge University and London Hospital; Manishankar Khushaldas Joshi, M.R.C.S., L.R.C.P., London Hospital; Thaddeus Julian, M.B., Ch.B. New Zealand, Otago University and Middlesex Hospital; Oswald Robert Michael Kelly, M.B., B.S. Lond., Westminster Hospital and King's College; Robert Kennon, M.B., Ch.B. Liverp., M.R.C.S., L.R.C.P., Liverpool University; William Ayer Lincoln, M.D., C.M., McGill, McGill University and Middlesex Hospital; Edwin Algernon Lindsay, M.R.C.S., L.R.C.P., Middlesex Hospital; Dermot Loughlin, M.B., B.S. Lond., M.R.C.S., L.R.C.P., London Hospital; Peter George McEvedy and Archibald Daniel Marston, L.D.S. Eng., Guy's Hospital; John Clifford Metcalfe, M.B., Ch.B. Leeds, Leeds University; Edward Thomas Campbell Milligan, M.D., B.S. Melb., Melbourne University and Middlesex Hospital; Hickman Walter Lancelot Molesworth, London Hospital; Gerald Thomas Mullally, M.B., B.S. Lond., M.R.C.S., L.R.C.P., Guy's Hospital; Ernest Farquhar Murray, M.D., B.Ch. St. And., St. Andrews University and Middlesex Hospital; George Ernest Neligan, M.A., M.B., B.Ch. Oxon., M.R.C.S., L.R.C.P., Oxford University and London Hospital; James Michael O'Donovan, University College, Cork; Richard Francis O'Sullivan, M.B., B.S. Melb., M.R.C.S., L.R.C.P., Melbourne University and Middlesex Hospital; John Hawkes Pendered, B.A., M.B., B.C. Cantab., M.R.C.S., L.R.C.P., Cambridge University and London Hospital; George Perkins, Oxford University and St. Thomas's Hospital; James Herbert Rawlinson, M.B., Ch.B. Liverp., Liverpool University; William Hugh Cowie Romanis, B.A. Cantab., and Ahmad Shafeek, M.D. Cairo, M.R.C.S., L.R.C.P., St. Thomas's Hospital; John Colvin Storey, M.B., Ch.M. Sydney, Sydney University and Middlesex Hospital; Arthur Sunderland, Charing Cross Hospital; Douglas George Clutsam Tasker, B.Sc. Bristol, Bristol University; Robert Allez Rotherham Wallace, M.B., Ch.M. Sydney, Sydney University and St. Bartholomew's Hospital; John Richard Menzies Whigham, M.B., B.S., M.R.C.S., L.R.C.P., St. Mary's Hospital; and Maurice Henry Whiting, M.B., B.C. Cantab., Cambridge University and Middlesex Hospital.

Licences in Dental Surgery have been conferred by the Council upon the following gentlemen:—

Rae Haydn Gaverick, Guy's Hospital; and Harold Woodhead Mawson, Leeds University.

MEDICAL BARRISTERS.—The following members of the medical profession have been called to the Bar:—Lincoln's Inn: A. B. Dunne, M.B. Cantab. Inner Temple: L. F. Hemmans, M.B. Durh. Middle Temple: H. T. Treves, M.R.C.S.; and H. W. G. Macleod, M.R.C.S. Gray's Inn: W. Moir, M.D. Aberd.; G. E. Oates, M.D. Lond.; G. Sowden, M.D. Brux.; and D. C. Kirkhope, M.D. Glasg.

THE POSITION OF PRISON MEDICAL OFFICERS.—The following resolution was passed unanimously at a small meeting of medical practitioners held on Nov. 18th, at 11, Chandos-street, London, W., to discuss the position of medical officers in His Majesty's prisons:—

This meeting of registered medical practitioners agrees with the statement of the editor of the *British Medical Journal* that "Prison medical officers are faced with a divided duty, that which they owe to their patients and that which they owe to their official superiors; and that the Home Office has no right to place them in this cruel dilemma." It therefore calls upon the Home Office to cease to require the prison medical officers to act under the direction of the lay authorities in professional matters and to abandon the practice of forcible feeding which has proved futile and which is only continued as a punishment.

EPSOM COLLEGE.—Of 11 boys who entered for the first examination for medical degrees at the University of London in July last ten passed in all subjects. The eleventh boy failed in chemistry only. One of the boys gained distinction for chemistry and physics, and another won an open scholarship of £75 at St. Mary's Hospital. Open scholarships, both in arts and science, have been gained this autumn at St. Bartholomew's Hospital by former pupils of Epsom College.

KING EDWARD'S HOSPITAL, CARDIFF.—A meeting of the governors of King Edward VII. Hospital, Cardiff, was especially called for Nov. 14th to consider a proposal to the effect that no one should be appointed to the medical staff of the hospital who was not a Member of the Royal College of Physicians of London or to the surgical staff unless he was a Fellow of the Royal College of Surgeons of England. The motion was defeated by a very small majority after a sharp discussion.

POOR-LAW MEDICAL OFFICERS' ASSOCIATION OF ENGLAND AND WALES.—A meeting of the council of this association was held at 34, Copthall-avenue, E.C., on Nov. 10th, Dr. J. B. G. Gidley-Moore being in the chair. A letter was read with regard to the dispute at West Ham. The medical officers of the union had been induced to submit to the demands of the guardians, and to consent to pay a portion of the expense of the drugs that it was proposed in the future should be supplied by the guardians. At the same time the guardians had consented that the salaries should remain unchanged, so that the future superannuation should not be affected by the payments of the medical officers. Much regret was expressed by the council at the surrender by the West Ham district medical officers of the important principle involved. It was very doubtful whether the future superannuation could be safeguarded in this manner. The Act laid down that the superannuation was to be based on the total emoluments at the time of the retirement; and therefore any payments made by the medical officers to the guardians would have to be deducted from the salaries. The council then took into consideration the Burnley dispute. The honorary secretary, Dr. Major Greenwood, read letters from Dr. A. P. Agnew giving details of the present state of affairs, from which it appeared that the condition of medical relief in the Burnley Union was very unsatisfactory. Only three of the 15 districts had medical officers, and the whole of the medical work had to be performed by three medical officers. The council instructed the honorary secretary to offer the assistance of the association in any way that the local profession might consider desirable. With regard to the appropriation of fees for attendance on panel patients among their employees by the Bethnal Green guardians, the honorary secretary reported that the action of the profession had not been as successful as might be desired. Much regret was expressed by the council, and several members commented on the apathy of a portion of their service in maintaining their rights. In connexion with this matter, the honorary secretary regretted that a distinctly retrograde step had been taken by the National Insurance Act Committee of the British Medical Association in their Poor-law policy. The council then considered the case of one of the district medical officers of the Wigan Union, who had held his office for 21 years. Up to three years ago his duties had been similar to those of most district medical officers, but since then he had constantly received orders from his relieving officer, given on the application of the police, to attend persons in charge of the police at the local police station. After discussion the council were unanimously of opinion that the strongest protest should be

made against such an innovation. It was hoped that the weighty representations made to the Government by their honorary secretary and by the British Medical Association might be effectual, and Dr. Greenwood was thanked for the care and attention he had given to the matter.

ANTARCTIC MEDALS.—The Royal Geographical Society has presented its special Antarctic Medal to Surgeon E. L. Atkinson, R.N., and Surgeon G. M. Levick, R.N., the surviving medical members of Captain Scott's last expedition.

THE DISTRICT COUNCIL OF ILFORD AND THE MEDICAL OFFICER OF HEALTH.—Mr. C. F. Stovin, the medical officer of health of Ilford, in his annual report for 1912, referred to restrictions placed upon his work by the local district council. The council thereupon applied to have the sanction of the Local Government Board for the determination of Mr. Stovin's appointment. An inquiry was held by a representative of the Local Government Board in July, the result of which was a new set of regulations for the working of the public health department. But at a special meeting of the Ilford district council on Wednesday evening last Mr. Stovin received three months' notice to terminate his office, on the grounds that he had not observed the new regulations. It is unlikely that this action will pass without protest when the full circumstances are known.

MIDLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.—The annual meeting of this society was held at the Medical Institute, Edmund-street, Birmingham, on Oct. 17th, Dr. Edward Malins, the president, being in the chair. The honorary general secretary read the annual report of the society for the session 1912–13. The society at present includes 71 members, constituted as follows: Original members, 43; members elected during the past session, 28. Five meetings have been held as under: at Birmingham, three meetings; at Bristol, one meeting; at Leicester, one meeting. The average attendance at these meetings was as follows: members, 12·6; visitors, 3·6. At the invitation of the North of England Obstetrical and Gynæcological Society a combined meeting was held with the Edinburgh, Glasgow, and North of England Societies at Manchester, on May 30th and 31st, 1913. The report further stated that the society has arranged with the *Journal of Obstetrics and Gynæcology of the British Empire* and the publishers of the same for the publication of the Transactions for the past year. A volume of Proceedings and Transactions has been published, and a copy sent to each member of the society. The council pointed out that the proceedings can only be done under the existing annual subscription (5*s.*) if the membership of the society is considerably increased. The adoption of the annual report and of the financial report was unanimous. The following officers and council were elected to serve for the session 1913–14. President: Dr. Walter Swayne. Vice-Presidents: Mr. Christopher Martin, Dr. Ewen J. Maclean, and Mr. H. T. Hicks. Council: Dr. Guy J. Branson, Dr. Annie Clark, Mr. E. Tenison Collins, Mr. Frederick Edge, Mr. J. Furneaux Jordan, Dr. Edward Malins, Mr. Cecil Marriott, Dr. W. H. Newnham, Mr. Miles H. Phillips, Dr. Thomas Wilson, and Mr. William Smith. Honorary Treasurer: Dr. C. E. Purslow. Honorary General Secretary: Mr. Beckwith Whitehouse. Honorary Local Secretaries: Mr. D. C. Raynor (for Western Counties) and Mr. T. C. Clare (for Eastern Counties). Dr. Swayne then delivered his presidential address upon the Relations between Universities and Medical Science. A vote of thanks to the President for his interesting address was proposed by Dr. Malins, seconded by Dr. Newnham, and carried unanimously.

## BOOKS, ETC., RECEIVED.

BALE (JOHN), SONS, AND DANIELSSON, LIMITED, London.

Problems for the Married. By Bernard M. Hancock, Author of "Preparation for Holy Matrimony," &c. Price 3*d.*; per doz., 1*s.* 6*d.*; per 100, 10*s.* 6*d.*

CHURCHILL, J. AND A., London.

The Control of Measles. By James Kerr, M.A., M.D., D.P.H., L. R. Lemprière, B.A., M.B., Reginald Dudfield, M.A., M.B., D.P.H., E. W. Goodall, M.D., B.S., C. J. Thomas, M.B., B.S., and C. B. Shelly, M.A., M.D. (Issued by the Medical Officers of Schools Association.) Price 1*s.* net.

FROWDE, HENRY, AND HODDER AND STOUGHTON, Edinburgh, Glasgow, and London.

Manual of Surgery. By Alexis Thomson, Professor of Surgery, University of Edinburgh; Surgeon, Edinburgh Royal Infirmary; and Alexander Miles, Surgeon, Edinburgh Royal Infirmary. Vol. III. Operative Surgery. Second edition. Price 10*s.* 6*d.* net.

HARRISON AND SONS, 45, 46, and 47, St. Martin's-lane, London, W.C.

Women's Voluntary Aid Detachments. Notes for Practice Meetings. Price 1*s.* net.

KIMPTON, HENRY, 263, High Holborn, London, W.C. STENHOUSE, ALEXANDER, 40 and 42, University Avenue, Glasgow.

Diagnosis and Treatment of Diseases of Women. By Harry Sturgeon Crossen, M.D., Associate Gynecologist, Washington University Hospital, and Associate in Gynecology, Washington University Medical School. Price 28*s.* net.

LAURIE, T. WERNER, LIMITED, Clifford's Inn, London, E.C.

Goldwin Smith: His Life and Opinions. By His Literary Executor, Arnold Haultain, Author of "Goldwin Smith's Correspondence." Price 18*s.* net.

Modern Woman and How to Manage Her. By Walter M. Gallichan. Price 1*s.* net.

Mrs. Edwards' Cookery Book. Price 6*s.* net.

Personal Experiences in Spiritualism (including the Official Account and Record of the American Palladino Séances). By Hereward Carrington. Price 7*s.* 6*d.* net.

# Appointments.

*Successful applicants for vacancies, Secretaries of Public Institutions, and others possessing information suitable for this column, are invited to forward to* THE LANCET *Office, directed to the Sub-Editor, not later than 9 o'clock on the Thursday morning of each week, such information for gratuitous publication.*

BARRINGTON-WARD, L. E., Ch.M., F.R.C.S. Edin., F.R.C.S. Eng., has been appointed Surgeon to Out-patients at the Hospital for Sick Children, Great Ormond-street.

BRIDGE, J. C., F.R.C.S. Edin., D.P.H. Camb., has been appointed Medical Inspector of Factories.

COOK, JOSEPH BASIL, M.D. Vict., D.P.H., has been appointed Medical Superintendent of the Brentford Union Infirmary, Isleworth.

CROWLEY, J. J., L.R.C.P. & S. Edin., L.F.P.S. Glasg., has been appointed Certifying Surgeon under the Factory and Workshop Acts for the Passage District of the county of Cork.

DORÉ, S. E., M.D. Camb., M.R.C.P. Lond., has been appointed Physician for Diseases of the Skin to Westminster Hospital.

DWYER, JAMES J., L.R.C.P. & S. Irel., has been appointed Clinical Assistant to the Chelsea Hospital for Women.

GOODDEN, HENRY WYNDHAM, M.B., Ch.B. Bristol, L.R.C.P., M.R.C.S., has been appointed Senior Resident Medical Officer at the Bristol Royal Infirmary.

HARWOOD-HARDMAN, FREDERICK, M.D. Edin., has been appointed Honorary Radiologist to the Princess Alice Memorial Hospital, Eastbourne.

JONES, D. W., M.B., B.S. Lond., has been appointed Resident Medical Officer at the Hospital for Consumption and Diseases of the Chest, Brompton.

LEY, GORDON, F.R.C.S. Eng., has been appointed Pathologist to the Chelsea Hospital for Women.

LONG, D. SANDERSON, M.D. Cantab., has been appointed Honorary Medical Officer to the York Dispensary.

MAILE, W. C. D., M.B., B.C. Cantab., M.R.C.S., L.R.C.P. Lond., has been appointed Resident Medical Officer at the City of London Lying-in Hospital.

PATRICK, JOHN, M.B., B.Ch. R.U.I., has been appointed Resident Medical Superintendent of Tyrone and Fermanagh Asylum.

ROSS, WILLIAM, F.R.C.S. Edin., has been appointed Examining Surgeon to the Collieries at Ebbw Vale, Monmouth.

TURNER, G. GREY, M.S. Durh., F.R.C.S. Eng., has been appointed Lecturer on Surgery in the University of Durham College of Medicine, Newcastle-upon-Tyne.

WHAITE, JOHN HENRY, M.D., B.Ch. Dub., has been appointed Medical Officer and Public Vaccinator of the Heavitree District by the St. Thomas's (Exeter) Board of Guardians.

# Vacancies.

*For further information regarding each vacancy reference should be made to the advertisement (see Index).*

ARGYLE AND BUTE ASYLUM, Lochgilphead.—Assistant Medical Officer, unmarried. Salary £200 per annum, with apartments, board, and laundry.

BATH, ROYAL MINERAL WATER HOSPITAL.—Resident Medical Officer. Salary £120 per annum, with lodging, board, and washing.

BETHNAL GREEN INFIRMARY AND WORKHOUSE, Cambridge Heath, E.—Second and Third Assistant Medical Officers. Salary at rate of £120 and £100 per annum respectively, with board, residence, and washing.

BIRMINGHAM AND MIDLAND HOSPITAL FOR SKIN AND URINARY DISEASES.—Clinical Assistant for three months. Salary at rate of 52 guineas per annum.

BIRMINGHAM, ROMSLEY HILL SANATORIUM FOR CONSUMPTIVES.—Assistant Resident Medical Officer, unmarried. Salary £200 per annum, with board, apartments, and laundry.

BOLTON UNION, TOWNLEYS HOSPITALS, Farnworth, near Bolton.—Resident Assistant Medical Officer. Salary £170 per annum, with apartments, washing, and attendance.

BRADFORD POOR-LAW UNION HOSPITAL AND WORKHOUSE.—Assistant Resident Medical Officer, unmarried. Salary £130 per annum, with rations, apartments, and laundry.

BRECON, BRECONSHIRE COUNTY COUNCIL.—County Medical Officer of Health and County School Medical Officer. Salary £500 per annum.

BRISTOL ROYAL INFIRMARY.—House Surgeon for six months for Throat, Nose, and Ear. Salary £75 per annum, with board, apartments, and laundry. Also Dental House Surgeon for six months. Salary at rate of £100 per annum, with board, apartments, and laundry. Also Honorary Assistant Physician.

BURY AND DISTRICT JOINT HOSPITAL BOARD.—Assistant Medical Superintendent. Salary £200 per annum, with board, washing, and lodging.

CAMBRIDGESHIRE COUNTY COUNCIL.—Tuberculosis Officer. Salary £300 per annum. Also Female Assistant County Medical Officer. Salary £300 per annum.

CANCER HOSPITAL.—Assistant in Chemical Department Research Institute. Salary £200 per annum.

CARDIFF, KING EDWARD VII.'s HOSPITAL.—Two Honorary Assistant Physicians. Also Senior Resident Medical Officer. Salary £120 per annum, with board, washing, and apartments.

CARMARTHEN, JOINT COUNTIES ASYLUM.—Second Assistant Medical Officer. Salary £180 per annum, with board, lodging, washing, &c.

CARSHALTON, SURREY, QUEEN MARY'S HOSPITAL FOR CHILDREN.—Senior Assistant Medical Officer. Salary £250 per annum, with board, lodging, and washing.

CHESTER, COUNTY ASYLUM.—Third Assistant Medical Officer, unmarried. Salary £180 per annum, with board, lodging, and washing.

CHESTER GENERAL INFIRMARY.—House Surgeon. Salary £100 per annum, with residence and maintenance.

COLCHESTER, ESSEX COUNTY HOSPITAL.—House Surgeon. Salary £100 per annum, with board, washing, and residence.

COVENTRY AND WARWICKSHIRE HOSPITAL, Coventry.—House Physician. Salary £110 per annum, with residence, board, laundry, and attendance.

DEVIZES, WILTS COUNTY ASYLUM.—Medical Superintendent. Salary £800 per annum, with partly furnished house, coal, light, washing, &c.

DORCHESTER, COUNTY ASYLUM.—Third Assistant Medical Officer. Salary £200 per annum, all found.

DORCHESTER, DORSET COUNTY HOSPITAL.—House Surgeon, unmarried. Salary £100 per annum, with residence, board, and laundry.

DOUGLAS, NOBLE'S HOSPITAL, ISLE OF MAN.—Resident House Surgeon, unmarried. Salary £100 per annum, with board and washing.

DOWN COUNTY COUNCIL.—Assistant Tuberculosis Medical Officer. Salary at rate of £350 per annum.

DREADNOUGHT HOSPITAL, Greenwich, S.E.—Medical Superintendent. Salary £150 per annum, with board, residence, and washing.

DUDLEY, GUEST HOSPITAL.—Assistant House Surgeon for six months. Salary £100 per annum, with residence, board, and washing.

EAST LONDON HOSPITAL FOR CHILDREN AND DISPENSARY FOR WOMEN, Shadwell, E.—House Physician. Salary at rate of £75 per annum, with board, residence, laundry, &c. Also Assistant Physician to Out-patients. Also Physician on Staff of Hospital.

EAST SUSSEX COUNTY COUNCIL EDUCATION COMMITTEE.—Junior Assistant School Medical Officer. Salary £250 per annum.

EDINBURGH, ROYAL ASYLUM, Morningside.—Assistant Physician. Salary £175 per annum, with apartments, board, and laundry.

ENFIELD EDUCATION COMMITTEE.—Ophthalmic Surgeon one half day of two hours per fortnight. £1 per attendance.

GLASGOW MATERNITY AND WOMEN'S HOSPITAL (Obstetrical Department).—Two Out-door House Surgeons. Also Female Out-door House Surgeon at West-End Branch for three months.

GLASGOW, VICTORIA INFIRMARY.—Assistant Physician.

GREAT YARMOUTH HOSPITAL.—House Surgeon, unmarried. Salary £100 per annum, with board, lodging, and washing.

GUILDFORD, ROYAL SURREY COUNTY HOSPITAL.—House Surgeon. Salary £75 per annum, with board, residence, and laundry.

HAMPSTEAD GENERAL AND NORTH-WEST LONDON HOSPITAL.—Surgeon to the Throat, Nose, and Ear Department.

HEMEL HEMPSTEAD, WEST HERTS HOSPITAL.—Resident Medical Officer. Salary £100 per annum, with rooms, board, and washing.

HOSPITAL FOR DISEASES OF THE SKIN, Stamford-street, Blackfriars.—Clinical Assistant.

HOSPITAL FOR SICK CHILDREN, Great Ormond-street, W.C.—Casualty Medical Officer. Salary £300 per annum, with luncheon. Also House Surgeon, unmarried, for six months. Salary £30, with board and residence.

HUDDERSFIELD ROYAL INFIRMARY.—Junior Assistant House Surgeon. Salary £80 per annum, with board, residence, and washing.

HULL ROYAL INFIRMARY.—Casualty House Surgeon for six months. Salary at rate of £90 per annum, with board and lodging.

INDIA OFFICE, London, S.W.—Dentists for British Troops in India.

ITALIAN HOSPITAL, Queen-square, W.C.—House Surgeon for six months. Salary £60 per annum, with board and residence.

LANCASHIRE EDUCATION COMMITTEE.—School Medical Inspector. Salary £350 per annum.

LIVERPOOL EYE AND EAR INFIRMARY, Myrtle-street.—House Surgeon. Salary at rate of £80 per annum.

MACCLESFIELD GENERAL INFIRMARY.—House Surgeon. Salary £125 per annum, with board and residence.

MAIDSTONE, KENT COUNTY ASYLUM.—Fourth Assistant Medical Officer, unmarried. Salary £200 per annum, with quarters, attendance, washing, &c.

MANCHESTER EDUCATION COMMITTEE.—Assistant School Medical Officer. Salary £250 per annum.

METROPOLITAN ASYLUMS BOARD.—Assistant Medical Officers, unmarried. Salaries: Second Assistant Medical Officer, £210 per annum; Third Assistant Medical Officer, £180 per annum, with board, lodging, and washing in each case.

MILLER GENERAL HOSPITAL FOR SOUTH-EAST LONDON, Greenwich-road, S.E.—Honorary Assistant Ophthalmic Surgeon.

MILROY LECTURES ON STATE MEDICINE AND PUBLIC HEALTH.—Milroy Lecturer for 1915.

NATIONAL HOSPITAL FOR DISEASES OF THE HEART, Westmoreland-street, W.—Resident Medical Officer for six months. Salary at rate of £80 per annum, with board, residence, and washing.

NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC, Queen-square, Bloomsbury.—Pathologist. Salary £250 per annum.

NEWCASTLE-UPON-TYNE AND NORTHUMBERLAND SANATORIUM FOR CONSUMPTIVES, Barrasford, North Tyne.—Resident Medical Officer, unmarried. Salary £250 per annum, with board, residence, and laundry.

NEWCASTLE-UPON-TYNE EDUCATION COMMITTEE.—Assistant Medical Officer. Salary £250 per annum.

NEW HOSPITAL FOR WOMEN, Euston-road.—Female House Physician, Two House Surgeons, and Obstetric Assistant for six months. Also Clinical Assistants for Out-patient Department and Assistant Pathologist.

NOTTINGHAM GENERAL DISPENSARY.—Resident Surgeon, unmarried. Salary £220 per annum, with apartments, attendance, light, and fuel.

OXFORD COUNTY ASYLUM, Littlemore, near Oxford.—Assistant Medical Officer. Salary £150 per annum, with apartments, board, and washing.

PORTSMOUTH ROYAL HOSPITAL.—House Physician for six months Salary £80 per annum, with board, &c.

RICHMOND, SURREY, ROYAL HOSPITAL.—Assistant House Surgeon. Salary £70 per annum, with board, apartments, and washing.

ROCHDALE INFIRMARY.—Senior House Surgeon, unmarried. Salary £110 per annum, with board, residence, and laundry.

ROCHESTER, ST. BARTHOLOMEW'S HOSPITAL.—Resident House Surgeon, unmarried. Salary at rate of £150 per annum, with board, residence, and laundry.

ROYAL BAR HOSPITAL, 42 and 43, Dean-street, Soho, London.—House Surgeon. Salary £40 per annum.

RYDE, ROYAL ISLE OF WIGHT COUNTY HOSPITAL.—Radiographer. Salary £40 per annum.

ST. MARY'S HOSPITAL FOR WOMEN AND CHILDREN, Plaistow, E.—Junior Resident Medical Officer for six months. Salary at rate of £70 per annum, with residence, board, and laundry.

ST. MARY'S HOSPITAL, Paddington, W.—Physician in charge of Out-patients.

SHEFFIELD ROYAL INFIRMARY.—House Surgeon for six months. Salary £80 per annum, with board and residence.

SMETHWICK, CORNWALL WORKS DISPENSARY.—Assistant Medical Officer.

SOUTHAMPTON, FREE EYE HOSPITAL.—House Surgeon. Salary £100 per annum, with board, lodging, and laundry.

SOUTH LONDON HOSPITAL FOR WOMEN.—Female Clinical Assistant.

SWANSEA UNION WORKHOUSE.—Assistant Medical Officer. Salary about £260 per annum.

TAUNTON, SOMERSET AND BATH ASYLUM, Cotford.—Assistant Medical Officer, unmarried. Salary £300 per annum, with apartments, board, washing, attendance, &c.

THROAT HOSPITAL, Golden-square, W.—Surgical Registrar.

UNIVERSITY OF LONDON.—Examiners.

VICTORIA HOSPITAL FOR CHILDREN, Tite-street, Chelsea, S.W.—Senior Resident Medical Officer. Salary £120 per annum, with board, residence, and washing.

WALSALL AND DISTRICT HOSPITAL.—Assistant House Surgeon. Salary £90 per annum, with board, residence, and laundry.

WEST LONDON HOSPITAL, Hammersmith-road, W.—House Physician for six months. Board, lodging, and laundry.

WEST SUSSEX AND CHICHESTER JOINT EDUCATION COMMITTEE.—Assistant School Medical Officer. Salary £400 per annum.

WIGAN, ROYAL ALBERT EDWARD INFIRMARY AND DISPENSARY.—Junior House Surgeon. Salary £100 per annum, with rations, apartments, and washing.

WORCESTER GENERAL INFIRMARY.—Resident Medical Officer. Salary £150 per annum, with board, residence, and washing. Also Clinical Assistant and Dispenser. Salary £80 per annum, with board, residence, and washing.

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THE Chief Inspector of Factories, Home Office, London, S.W., gives notice of vacancies as Certifying Surgeons under the Factory and Workshop Acts at Kirkliston, in the county of Linlithgow; and at Milltown, in the county of Kerry.

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*** The summary of vacant appointments, published weekly in this column, is, equally with other articles, the literary copyright of the Proprietors of THE LANCET.

# Births, Marriages, and Deaths.

## BIRTHS.

LINDSEY.—On Nov. 6th, at Beaumont, Irving-road, West Southbourne, Bournemouth, the wife of Mark Lindsey, M.R.C.S., L.R.C.P., of a son.

## MARRIAGES.

DICK—WALLACE.—At the Highgate Presbyterian Church, on Nov. 8th, by the Rev. Alexander Ramsay, B.D., James Reid Dick, M.B., B.C. Cantab., Scarborough, to Davina Orford, daughter of William Wallace, of 5, Broadlands-road, Highgate, London.

## DEATHS.

BOWLES.—On Nov. 15th, at Priors Mesne, Lydney, Gloucestershire, Robert Leamon Bowles, M.D., F.R.C.P., late of Folkestone and Upper Brook-street, London, aged 79 years.

BRIDGMAN.—On Nov. 17th, at Streatham, after a long illness, Herbert Arthur Bridgman, L.S.A., L.R.F.P.S. Glasg., formerly practising at Henley, Batley, and Victoria Park, and late District Surgeon, Natal.

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*N.B.—A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.*

# Notes, Short Comments, and Answers to Correspondents.

## HEALTH CONDITIONS IN THE NORTHERN TERRITORY.

THE northern territory of Australia occupies the centre of the continent between 129-138° East longitude as far as 26° South latitude. The administration of the territory was taken over by the Commonwealth in 1911, and a report upon health and disease in the country was issued in the same year drawn up by Dr. A. Breinl, director of the Australian Institute of Tropical Medicine. This report was noticed in our issue of March 13th. We have now before us the report of Dr. Mervyn J. Holmes, medical officer of health of the territory. Dr. Holmes has lost no time in preparing and presenting his report, as he mentions that he has held the post for scarcely more than six months. Consequently, he says the report deals "more with things as they are and with the steps which are being taken, or which are about to be taken, for the removal or remediation of insanitary conditions, rather than with what has actually been done in this respect." As for the general health of the country Dr. Holmes considers that the natural conditions of the territory are very favourable to health; serious outbreaks of disease rarely occur, the great tropical diseases are seldom met with, and in addition typhoid fever and pneumonia are rare; diphtheria and scarlet fever are practically unknown. The diseases which have most influence on the health of the territory are venereal complaints, malaria, dysentery, and tuberculosis. Granuloma and yaws are practically confined to aboriginals. Malaria is not so prevalent as it is popularly supposed to be. It has most likely been introduced from other countries, and Dr. Holmes considers that with due attention to sanitation and preventive measures it could be totally eradicated.

The main portion of the report is concerned with the sanitary condition of Port Darwin. The town itself occupies a most advantageous position from a hygienic point of view, but owing to there having been no control over building operations or refuse disposal, including night-soil, sanitary conditions are very far from satisfactory. Regulations, however, have been framed with a view to remedying present evils, and Dr. Holmes concludes by saying that the ratification of these regulations will greatly strengthen the hands of the authorities in preserving and improving the public health.

## THE CASE OF MR. H. T. HAMILTON.

*To the Editor of* THE LANCET.

SIR,—To the donations already acknowledged (i.e., £61 1s. 6d.) I have now to add the following: Dr. J. Thoresby Jones, Sutherland-avenue, W., 10s. 6d.

I am, Sir, yours faithfully,

W. H. GIMBLETT, M.D.

86, Sutherland-avenue, Maida Vale, W., Nov. 18th, 1913.

## THE SPREAD OF THE METRIC SYSTEM.

THE Decimal Association has requested us to publish the following, which will be of interest to a considerable number of medical men:—

In the Parliamentary debate of March, 1907, the small majority opposed to the Weights and Measures (Metric System) Bill was obtained in part by the argument that our trade with the East might suffer through suspicion and distrust on the part of our Oriental customers if we presented to them such a novelty as the metric system in selling goods. America also, it was said, might take advantage of this by continuing to use the yard and pound so popular in the East. This objection was groundless, because the Bill did not relate to foreign trade at all, and permitted manufacturers to make goods for export of any size, pattern, mark, or description, and to sell them as they chose.

The time is soon coming when metric usage, instead of being regarded as a hindrance to British trade with the Far East, will have to be adopted as a necessity in our dealings with China, Japan, and Siam, which have each taken definite steps to establish that system. Already the Advisory Council of China has passed the first reading of a law to that effect, and there are now in Paris two Chinese gentlemen studying at the International Bureau of Weights and Measures the technical details of the subject with a view to completing what is planned.

Japan has for the present four legal systems of weight and measure; (1) the metric; (2) the shaku-kwan; (3) the kujira-shaku; and (4) the British yard and pound. The Government has declared its preference for the metric system by making it obligatory for the services of the customs, excepting a few articles. It is taught in all the public schools, and is prescribed for the army, for medicine, and for electrical work. The carat for precious stones is now 200 milligrammes. A specially heavy charge (more than threefold) is made for the verification of British weights and measures, and the public registers show a steady increase in metric usage.

Siam has for some years employed the metric system with much success on its railways and public works, and last year joined the International Convention of the Metre, from which it has received the apparatus needed for a Central Bureau of Standards at Bangkok. It should interest India to know that the Sanskrit element in the Siamese language has proved useful in connexion with the names of the metric units. Siam proposes not to make metric reform compulsory at one and the same time in all parts of the kingdom, but to deal with each province separately at convenient times—a plan which might perhaps be usefully followed by Russia, China, and India.

Russia also, which is now one of the great Powers of the Far East, has adopted the metric system for several purposes, and has announced to the Decimal Association by a recent letter from the Ministry of Commerce and Industry that the metric system is favoured, but has to await the necessary arrangement of control and inspection throughout the Empire with its 165 millions of people. This conversion of Russia is notable as completing the solidarity of all Continental Europe in metric reform, and as being likely to hasten the action of China, her eastern neighbour.

This note is mainly devoted to metric progress in Far Eastern countries, but it must not be forgotten that all South and Central America are either metric or tending to be so. The Australasian Dominions of Great Britain have urgently pressed the question on her notice, and last, but most important of all as a source of external influence, are the United States of America, which have gone far in preparing for reform, and will act with vigour when the time comes, for they know the truth declared in 1790 by Thomas Jefferson, afterwards their president, that the decimal system then established by him in their money would also in weights and measures bring "the calculation of the principal affairs of life within the arithmetic of every man who can multiply and divide plain numbers." The whole world has now approved his words, and the United States of America are on the way to fulfil them.

## A CHEMICAL RETROSPECT.

Sir William Crookes has issued through his publishers at the *Chemical News* office, 16, Newcastle-street, Farringdon-street, London, E.C., a general index (a copy of which has reached us) of the *Chemical News* from the time of its inception up to the year 1909. This journal has now been in existence for 70 years, and under Sir William Crookes's editorship for the greater part of this time, and has served most usefully to record the progress of chemical and allied sciences. The value of the index is therefore obvious. Considerable pains have been taken to render it a trustworthy source of reference and the plan has been adopted of including in it both subjects and authors. This has rendered it a somewhat large volume, but the method facilitates reference, for it sometimes happens that the name of an author escapes memory or the subject connected with his name may be forgotten. Since the references go back so far the index enables the reader to trace the development in many cases of industrial science, analytical processes, and so forth. Whilst recording an appreciation of Sir William Crookes's services to chemical science, which are reflected in this index, we may take the opportunity of congratulating him upon the recent announcement of his appointment to the Presidency of the Royal Society.

## INTESTINAL STASIS.

*To the Editor of* THE LANCET.

SIR,—In announcing my book, "A Doctor's Discovery," in your advertising pages this week I hope you will permit me to call the attention of your readers to it. But for trouble with the printer it would have appeared three years ago. Since it was written I have continued my experiments and observations on the physiological action of food, and they all tend to confirm the conclusion at which I arrived—viz., that food is the chief cause of disease. Physicians are much indebted to Sir Arbuthnot Lane for the proof he gives of the dreadful results of intestinal stasis. There can be no doubt that when the great drain of the system, the intestinal track, is in any way obstructed disease will result; but what the physician ought to know is the primary cause of the intestinal stasis. Having discovered the primary cause, and removed it, the stasis may be overcome in time to save the patient from coming into the hands of the surgeon. Sir Arbuthnot Lane warns the profession as to the danger of animal food; but I find that cereals, and even some vegetables, are quite as capable of causing intestinal stasis as animal food, and until

the physiological action of our various foods is studied and known we cannot hope to be able to prescribe such foods as will prevent intestinal stasis. Some, I find, cause not only intestinal but renal stasis, and when the two are combined the strain upon the skin and lungs, as seen in the insensible perspiration, is greatly increased. I sometimes lose as much as 38 ounces in weight during the night from the skin and lungs alone, and occasionally I appear to gain weight without anything having entered the stomach, a mystery which still remains to be solved; but, however it may be explained, it proves that there are other stases in addition to stasis of the intestine, which the physician of the future must study to maintain his reputation as a physician, of which surgeons are rapidly depriving him.

I am, Sir, yours faithfully,

JOHN HADDON, M.D. Edin.

Denholm, Hawick, Nov. 11th, 1913.

## A WARNING.

Messrs. J. and A. Churchill ask us to announce that a warrant is out for the arrest of a man who professes to be travelling books for their firm, but who has never been employed by them. He calls on medical practitioners with samples of Messrs. Churchill's books and seeks to obtain orders and payments. Among other names he uses are those of Williams and Longford. He should be detained while the police are communicated with.

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*Ophthalmos* wishes to know if there are any special courses on ophthalmology and otology to be held in Wiesbaden during the winter, and if so, what are the fees and names of the clinics.

*E. B. R. and Others.*—Our correspondents are thanked for messages of congratulation.

COMMUNICATIONS not noticed in our present issue will receive attention in our next.

# Medical Diary for the ensuing Week.

## SOCIETIES.

**ROYAL SOCIETY**, Burlington House, London, W.

THURSDAY.—Prof. B. Hopkinson: A Method of Measuring the Pressure Produced in the Detonation of High Explosives or by the Impact of Bullets.—Mr. J. H. Jeans: Gravitational Instability and the Nebular Hypothesis.—Mr. B. A. Keen and Mr. A. W. Porter: On the Diffraction of Light by Particles Comparable with the Wave Length.—Prof. R. J. Strutt: Note on the Colour of Zircons and its Radio-active Origin.—Prof. W. H. Bragg: The Influence of the Constituents of the Crystal on the Form of the Spectrum in the X Ray Spectrometer.—Mr. W. L. Bragg: The Analysis of Crystals by the X Ray Spectrometer (communicated by Prof. W. H. Bragg).—And other papers.

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**ROYAL SOCIETY OF MEDICINE**, 1, Wimpole-street, W.

MONDAY.

SECTION OF ODONTOLOGY (Hon. Secretaries—Robert McKay, F. Coleman): at 8 P.M.

Mr. F. St. J. Steadman: Case of Rheumatoid Arthritis Cured by the Removal of Septic Teeth.

Dr. T. J. Herder: Dental Sepsis from the Point of View of the Physician.

TUESDAY.

SECTION OF MEDICINE (Hon. Secretaries—H. Batty Shaw, John Fawcett): at 5.30 P.M.

Dr. A. M. Gossage and Dr. Braxton-Hicks: Two Cases of Non-cancerous Tumour of the Stomach.

Dr. Newton Pitt: A Calcareous Deposit on a Fish Bone in the Parotid Duct.

Dr. Batty Shaw and Mr. R. Higham Cooper: On a Change in the Pelvis occurring in a Case of Pre-puberal Atrophy of the Testicles.

Dr. Percy Kidd: Case of Combined Sclerosis of the Spinal Cord with (?) Dystrophia Adiposo-genitalis. (The case will be shown at 5 P.M., previous to the meeting.)

FRIDAY.

SECTION FOR THE STUDY OF DISEASE IN CHILDREN (Hon. Secretaries—F. Langmead, Philip Turner, William J. Midelton): at 4.30 P.M.

Dr. F. G. Crookshank and Mr. Lionel E. Norbury: Double Congenital Hip in Twins.

Mr. Philip Turner and Dr. H. Tipping: Case of Mesenteric Cyst Simulating an Intussusception.

Dr. C. E. Zundel: Infantilism associated with Recrudescent Rickets and Tuberculosis.

Mr. W. J. Midelton: Two Cases of Dermatitis Herpetiformis Successfully Treated by Continuous Counter-irritation.

Dr. F. J. Poynton: (1) Osteogenesis Imperfecta; (2) Case for Diagnosis.

Dr. Frederick Langmead: Two Sisters with Deformity of Bones and Splenomegaly.

Dr. F. G. Crookshank: Skiagrams of a Case of Dactylar Deformity with Amniotic Bands.

And other Cases.

SECTION OF EPIDEMIOLOGY AND STATE MEDICINE (Hon. Secretaries—G. S. Buchanan, William Butler): at 8.30 P.M.

Dr. E. C. Snow: The Mortality from Phthisis: a Statistical Investigation having Bearing upon the Question of Personal Communicability.

Dr. Hilda Clark: Tuberculosis Statistics: a Note on Some Difficulties in the Selection and Estimation of Facts observed in Modern Clinical Tuberculosis Work.

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**MEDICAL SOCIETY OF LONDON**, 11, Chandos-street, Cavendish-square, W.

MONDAY.—8 P.M., Clinical Evening.

**MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND**, 11, Chandos-street, Cavendish-square, W.

MONDAY.—2.30 P.M., Status of M.O. and Psychiatry Committee.

TUESDAY.—1.45 P.M., Council Meeting. 3. P.M., General Meeting. Papers:—Dr. E. Faulks: (1) Electrolytic Chlorine Bleach for Asylum Laundries; (2) An Automatic Temperature Regulator for the Continuous Hot Bath.—Adjourned Discussion on Dr. Getting's paper on Asylum Dysentery.

**HUNTERIAN SOCIETY**, St. Bartholomew's Hospital (Library), E.C.

WEDNESDAY.—9 P.M., Discussion on Migraine (opened by Dr. A. Currie). The following gentlemen will also take part:—Mr. S. Stephenson, Dr. F. Taylor, Mr. C. Wray, and Mr. A. Evershed.

**CHILD STUDY SOCIETY, LONDON**, Royal Sanitary Institute, 90, Buckingham Palace-road, S.W.

THURSDAY.—7.30 P.M., Joint Meeting with Froebel Society for Discussion on the Educational and Psychological Aspect of the Training of Children before School Age.

**HARVEIAN SOCIETY OF LONDON**, Stafford Rooms, Titchborne-street, Edgware-road, W.

THURSDAY.—8.30 P.M., Discussion on the Registration of Venereal Diseases. The following have promised to take part: Dr. Stevenson, Dr. Blacker, Dr. Cautley, Dr. Maude, and Dr. Dudfield.

## LECTURES, ADDRESSES, DEMONSTRATIONS, &c.

**MEDICAL GRADUATES' COLLEGE AND POLYCLINIC**, 22, Chenies-street, W.C.

MONDAY.—4 P.M., Dr. S. E. Dore: Clinique (Skin). 5.15 P.M., Lecture:—Dr. C. Riviere: Common Pitfalls in the Physical Examination of the Chest.

TUESDAY.—4 P.M., Dr. R. Smith: Clinique (Medical). 5.15 P.M., Lecture:—Dr. C. M. H. Howell: Brachial Neuritis.

WEDNESDAY.—4 P.M., Mr. C. Ryall: Clinique (Surgical). 5.15 P.M., Lecture:—Mr. G. W. Thompson: Eye Strain, its Multiform Consequences and Management.

THURSDAY.—4 P.M., Mr. E. R. Carling: Clinique (Surgical). 5.15 P.M., Lecture:—Mr. C. S. Frankau: Subphrenic Abscess.

FRIDAY.—4 P.M., Mr. W. Stuart-Low: Clinique (Ear, Nose, and Throat). 5.15 P.M., Lecture:—Dr. W. Wingrave: New Method of Blood-staining.

**POST-GRADUATE COLLEGE**, West London Hospital, Hammersmith-road, W.

MONDAY.—10 A.M., Dr. Simson: Diseases of Women. 10.30 A.M., Medical Registrar: Demonstration of Cases in Wards. 12 noon, Dr. Bernstein: Pathological Demonstration. 2 P.M., Medical and Surgical Clinics. X Rays. Mr. Armour: Operations. 2.30 P.M., Mr. Dunn: Diseases of the Eye. 5 P.M., Lecture:—Mr. Pardoe: Genito-urinary Surgery.

TUESDAY.—10 A.M., Dr. Robinson: Gynæcological Operations. 10.30 A.M., Surgical Registrar: Demonstration of Cases in Wards. 12 noon, Mr. T. Gray: Demonstration of Fractures, &c. 2 P.M., Medical and Surgical Clinics. X Rays. Mr. Baldwin: Operations. Dr. Davis: Diseases of the Throat, Nose, and Ear. Dr. Pernet: Diseases of the Skin. 5 P.M., Lecture:—Mr. Pardoe: Genito-urinary Surgery.

WEDNESDAY.—10 A.M., Dr. Saunders: Diseases of Children. Dr. Davis: Operations of the Throat, Nose, and Ear. 11 A.M., Mr. Souttar: Demonstration of Minor Operations. 12 noon, Lecture:—Mr. Souttar: Abdominal Diagnosis. 2 P.M., Medical and Surgical Clinics. X Rays. Mr. Pardoe: Operations. Mr. B. Harman: Diseases of the Eye. Dr. Simson: Diseases of Women. 5 P.M., Lecture:—Mr. Pardoe: Genito-urinary Surgery.

THURSDAY.—10.30 A.M., Dr. Simson: Gynæcological Demonstration. 12.15 P.M., Lecture:—Dr. G. Stewart: Neurological Cases. 2 P.M., Medical and Surgical Clinics. X Rays. Mr. Armour: Operations. 2.30 P.M., Mr. Dunn: Diseases of the Eye. 5 P.M., Lecture:—Dr. G. Stewart: Syphilitic Diseases of the Nervous System.

FRIDAY.—10 A.M., Dr. Robinson: Gynæcological Operations. 10.30 A.M., Lecture:—Dr. Owen: Practical Medicine. 12.15 P.M., Lecture:—Dr. Bernstein: Clinical Pathology. 2 P.M., Medical and Surgical Clinics. X Rays. Mr. Baldwin: Operations. Dr. Davis: Diseases of the Throat, Nose, and Ear. Dr. Pernet: Diseases of the Skin. 5 P.M., Lecture:—Dr. G. Stewart; Syphilitic Diseases of the Nervous System.

SATURDAY.—10 A.M., Dr. Saunders: Diseases of Children. Dr. Davis: Operations of the Throat, Nose, and Ear. Mr. B. Harman: Diseases of the Eye. 12 noon, Lecture:—Mr. Souttar: Surgical Anatomy of the Abdomen. 2 P.M., Medical and Surgical Clinics. X Rays. Mr. Pardoe: Operations.

**LONDON SCHOOL OF CLINICAL MEDICINE**, Dreadnought Hospital, Greenwich.

MONDAY.—Out-patient Demonstrations:—10 A.M. Dr. Singer: Medical. Mr. H. Curtis: Surgical. 12 noon, Mr. G. N. Bigg: Throat, Nose, and Ear.—2.15 P.M., Mr. W. Turner: Surgery. 3 P.M., Mr. W. Turner: Operations. 3.15 P.M., Sir Dyce Duckworth: Medicine. 4.15 P.M., Mr. R. Lake: Ear and Throat.

TUESDAY.—Out-patient Demonstrations:—10 A.M., Dr. G. Holmes: Medical. Mr. Cole: Surgical. 12 noon, Dr. H. MacCormac: Skin.—2 P.M., Mr. L. McGavin: Operations. 2.15 P.M., Mr. E. Carling: Surgery. 3.15 P.M., Dr. G. Rankin: Medicine.

WEDNESDAY.—Out-patient Demonstrations: 10 A.M., Dr. F. Langmead: Medical. Mr. Cecil Rowntree: Surgical. 11 A.M., Mr. S. B. Bickerton: Eye.—2 P.M., Mr. L. V. Cargill or Mr. Choyce: Operations. 2.15 P.M., Dr. F. Taylor: Medicine. 3.15 P.M., Mr. Cargill: Eye Clinique. 4.30 P.M., Mr. C. C. Choyce:

Surgery. Special Lecture:—Dr. J. Taylor: Significance of Ocular and Visual Conditions in Nervous Disease.

THURSDAY.—Out-patient Demonstrations:—10 A.M., Dr. Singer: Medical. Mr. H. Curtis: Surgical. 12 noon, Mr. G. N. Biggs: Throat, Nose, and Ear.—2 P.M., Mr. R. Carling or Mr. W. Turner: Operations. Dr. A. Davies: Pathological Demonstration. 3.15 P.M., Dr. R. Wells: Medicine. 4.30 P.M., Special Lecture:—Mr. A. Carless: The Diagnosis of an Acute Abdomen.

FRIDAY.—Out-patient Demonstrations:—10 A.M., Dr. G. Holmes: Medical. Mr. Cole: Surgical. 12 noon, Dr. H. MacCormac: Skin.—2 P.M., Mr. L. McGavin: Operations. 2.15 P.M., Sir John Rose Bradford; Medicine. 3.15 P.M., Mr. L. McGavin: Surgery.

SATURDAY.—Out-patient Demonstrations: 10 A.M., Dr. F. Langmead: Medical. Mr. Cecil Rowntree: Surgical. 11 A.M., Mr. R. H. Bickerton: Eye.—10 A.M., Col. Barry: Radiography.

**NORTH-EAST LONDON POST-GRADUATE COLLEGE**, Prince of Wales's General Hospital, Tottenham, N.

MONDAY.—Clinics:—10.30 A.M., Surgical Out-patient (Mr. R. Gillespie). 2.30 P.M., Medical Out-patient (Dr. T. R. Whipham); Nose, Throat, and Ear (Mr. H. D. Gillies). 3 P.M., Clinical Pathology and Pathological Demonstration (Dr. W. H. Duncan).

TUESDAY.—Clinic: 2 P.M., Recent Advances in Syphilis (Dr. Macdonald). 2.30 P.M., Operations. Clinics:—Medical Out-patient (Dr. A. G. Auld); Surgical (Mr. Howell Evans); Gynæcological (Dr. A. E. Giles). 3 P.M., Select Cases illustrating the Connexion Between Cutaneous and Digestive or Biliary Disturbances. 4.30 P.M, Recent Advances in the Treatment of Heart Disease (Dr. Whiting).

WEDNESDAY.—Clinics:—2 P.M., Throat Operations (Mr. Gillies). 2.30 P.M., Children's Out-patient (Dr. T. R. Whipham); Skin (Dr. G. N. Meachen); Eye (Mr. R. F. Brooks). 3 P.M., X Rays (Mr. W. Steuart); Clinical Pathology and Pathological Demonstration (Dr. W. H. Duncan). 5.30 P.M., Eye Operations (Mr. Brooks).

THURSDAY.—2.30 P.M., Gynæcological Operations (Dr. A. E. Giles). Clinics:—Medical Out-patient (Dr. A. J. Whiting); Surgical (Mr. Carson). 3 P.M., Medical In-patient (Dr. G. P. Chappel).

FRIDAY.—2.30 P.M., Operations. Clinics:—Medical Out-patient (Dr. A. G. Auld); Surgical (Mr. R. Gillespie); Eye (Mr. R. P. Brooks). 3 P.M., Medical In-patient (Dr. R. M. Leslie); Clinical Pathology and Pathological Demonstration (Dr. W. H. Duncan).

**LONDON HOSPITAL MEDICAL COLLEGE** (UNIVERSITY OF LONDON) Clinical Theatre, London Hospital, Mile End-road, E.
Course of Lectures on the Neuroses and Psychoses of Children:—

TUESDAY.—2 P.M., Dr. F. Warner: Children Mentally Defective.

**HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST**, Brompton, S.W.

WEDNESDAY.—4.30 P.M., Lecture:—Dr. Wethered: The Febrile State in Pulmonary Tuberculosis.

**NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC**, Queen-square, Bloomsbury, W.C.

TUESDAY.—3.30 P.M., Clinical Lecture:—Dr. F. Batten: Rarer Manifestations of Poliomyelitis.

FRIDAY.—3.30 P.M., Clinical Lecture:—Dr. A. Turner: Clinical Cases.

**THE THROAT HOSPITAL**, Golden-square, W.

MONDAY.—5.15 P.M., Special Demonstration of Selected Cases.

THURSDAY.—5.15 P.M., Clinical Lecture.

**ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN**, 49, Leicester-square, W.C.

TUESDAY.—6 P.M., Mr. Hampson: X Rays—Measurement of Dose.

THURSDAY.—6 P.M., Dr. M. Dockrell: Tuberculosis of the Skin—I., Lupus Vulgaris; II., Tuberculosis Verrucosa Cutis; III., Scrofuloderma.

**MANCHESTER HOSPITALS POST-GRADUATE CLINIC.**

TUESDAY.—SALFORD ROYAL HOSPITAL—4.30 P.M., Dr. C. E. Lea: Treatment of Irregular Heart.

WEDNESDAY.—ROYAL INFIRMARY—4.30 P.M., Dr. Brockbank: Mediastinal Growths.

THURSDAY.—ANCOATS HOSPITAL—4.30 P.M., Exhibition of Medical and Surgical Cases by Honorary Staff.

FRIDAY.—ROYAL EYE HOSPITAL—4.30 P.M., Dr. J. Wharton: Retinitis.

**UNIVERSITY OF SHEFFIELD POST-GRADUATE CLINICAL DEMONSTRATIONS.**

TUESDAY.—SHEFFIELD ROYAL INFIRMARY.—3 P.M., Dr. B. Hallam: Diagnosis and Treatment of Skin Diseases Commonly Met with in General Practice.

FRIDAY.—SHEFFIELD ROYAL INFIRMARY.—3 P.M., Dr. A. Connell: Common Injuries of Bones and Joints—their Treatment.

**ROTUNDA HOSPITAL POST-GRADUATE COURSES**, Dublin.

MONDAY.—10 A.M., Obstetrical Lecture: Displacements of the Uterus during Pregnancy. 11 A.M., Examination of Patients and Minor Operations.

TUESDAY.—10 A.M., Major Operations.

WEDNESDAY.—10 A.M., Obstetrical Lecture: The Effect of Uterine Tumours on Pregnancy and Labour. 11 A.M., Examination of Patients and Minor Operations.

THURSDAY.—10 A.M., Major Operations.

FRIDAY.—10 A.M., Gynæcological Lecture: Vaginal Tumours (continued). 11 A.M., Examination of Patients and Minor Operations.

*For further particulars of the above Lectures, &c., see Advertisement Pages.*

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## METEOROLOGICAL READINGS.

*(Taken daily at 8.30 a.m. by Steward's Instruments.)*

THE LANCET Office, Nov. 19th, 1913.

| Date. | Barometer reduced to Sea Level and 32° F. | Direction of Wind. | Rainfall. | Solar Radio in Vacuo. | Maximum Temp. Shade. | Min. Temp. | Wet Bulb. | Dry Bulb. | Remarks. |
|---|---|---|---|---|---|---|---|---|---|
| Nov. 13 | 29·12 | W. | 0·39 | 53 | 51 | 44 | 44 | 44 | Raining |
| ,, 14 | 29·35 | S.W. | 0·29 | 77 | 53 | 44 | 46 | 46 | Raining |
| ,, 15 | 29·64 | S.W. | 0·10 | 75 | 56 | 43 | 42 | 43 | Fine |
| ,, 16 | 29·93 | S.W. | ... | 64 | 54 | 43 | 45 | 47 | Cloudy |
| ,, 17 | 30·07 | S.W. | ... | 83 | 60 | 46 | 54 | 55 | Overcast |
| ,, 18 | 30·07 | S.W. | 0·01 | 85 | 59 | 55 | 54 | 56 | Overcast |
| ,, 19 | 30·38 | S.W. | 0·09 | 70 | 51 | 42 | 41 | 43 | Cloudy |

**The following journals, magazines, &c., have been received:**—Canadian Practitioner and Review, Tropical Diseases Bulletin, Archives Internationales de Neurologie, Centralblatt für Allgemeine Pathologie und Pathologische Anatomie, Albany Medical Annals, London Hospital Gazette, International Journal of Surgery, American Medicine, Medical Review, Bulletin Mensuel de l'Office International d'Hygiène Publique, Symons's Meteorological Magazine, Biometrika, Revue de Médecine, Revue de Chirurgie, Clinique Ophtalmologique, Revue de Gynécologie.

## Communications, Letters, &c., have been received from—

A.—Messrs. Allen and Hanburys, Lond.; Mr. H. G. L. Allford, St. Leonards-on-Sea.

B.—Messrs. Burroughs Wellcome and Co., Lond.; Dr. J. B. Berkart, Lond.; *British Dental Journal*, Lond., Editor of; Messrs. Butterworth and Co., Lond.; Dr. M. R. Bisset, Heywood; Mr. W. Bryce, Edinburgh; Dr. W. A. Brend, Lond.; Messrs. C. Barker and Sons, Lond.; Dr. Charles Bolduan, New York; Dr. Philip Boobbyer, Nottingham; Dr. W. Seaman Bainbridge, New York; Dr. B. Blacklock, Runcorn; Mr. James Bell, Lond.

C.—Messrs. Condy and Mitchell, Lond.; Chester County Asylum, Medical Superintendent of; Mr. H. A. Collins, Croydon; Cambridgeshire County Council, Cambridge, Clerk to the; Messrs. J. and A. Churchill, Lond.; Coventry and Warwickshire Hospital, Secretary of; City of London Mental Hospital, Dartford, Medical Superintendent of; Dr. L. G. Cole, New York; Mr. N. Curtis, Lond.; Messrs. Carnrick and Co., Lond.; Messrs. E. Cook and Co., Lond.; Dr. H. Warren Crowe, Yelverton; Chelsea Hospital for Women, Lond., Secretary of; Messrs. Carfax, Lond.; Dr. S. Wellesley Coombs, Worcester.

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I.—Institute of Hygiene, Lond., Secretary of.

J.—Joint Counties Asylum, Carmarthen, Clerk to the; Dr. A. W. Jagger, Flushing, U.S.A.; Jamaica, Registrar-General of, Kingston.

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O.—Dr. W. D. O'Kelly, Dublin.

P.—Paddington Guardians, Lond., Clerk to the; Poplar Corporation, Lond., Medical Officer of Health to the; Messrs. Peacock and Hadley, Lond.; Dr. T. Wilson Parry, Lond.

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T.—Dr. P. C. B. Tribe, Cairo; Dr. H. P. Tayler, Exmouth; Mr. J. Thin, Edinburgh; Dr. A. L. Taylor, Derby; Dr. Leslie Thorne Thorne, Lond.

U.—University of London Press, Lond.

V.—Victoria Infirmary, Glasgow, Secretary of; Vejlefjord Sanatorium, Secretary of.

W.—Mrs. Walker, Lond.; *Wiltshire Gazette*, Devizes, Manager of; West Sussex and Chichester Joint Education Committee, Worthing, Secretary of; Messrs. J. Woodhead and Sons, Huddersfield; Mr. J. Williams, Bradford; Mr. A. C. Watken, Shrewsbury; Walsall and District Hospital, Secretary of; West Herts Hospital, Hemel Hempstead, Clerk to the; Dr. T. Wise, Montreux; West Riding County Council, Wakefield, Secretary of; Messrs. F. Williams and Co., Lond.; Dr. M. H. Williams, Colwall; Dr. H. M. M. Woodward, Lond.; Wiltshire, Medical Officer of Health of, Trowbridge; Mr. Beckwith Whitehouse, Birmingham.

## Letters, each with enclosure, are also acknowledged from—

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